SCALPEL

Newsletter of Association of Surgeons of India

SEPTEMBER 2022

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Newsletter of Association of Surgeons of India

From the desk of President

Dear Colleagues,

It gives me immense pleasure to once again bring to you this edition of the Official Newsletter of ASI – "SCALPEL". With an entire new array of articles, trials, case reports, interviews and invited extracurricular posts. The articles have been contributed by our members from across the length and breadth of the country. The Editorial team comprising of Dr. Tarun Mittal, Dr. Madhumita Mukhopadhyay and Dr. Rajesh Prajapati, has come up with another exciting edition of the Newsletter which covers an extensive collection of academic and non-academic topics.

Now that the pandemic is probably in its wane and more and more events and conferences are hosted physically we also look forward to this year's annual conference of ASI, ASICON 2022 being hosted by the Mumbai team from 21st to 24th December 2022. And I wish them all the best to make it a memorable event. The executive body of ASI will continue to support the local organising committee to do their jobs with vigour and enthusiasm and take the conference participation to greater heights.

As I have mentioned before, the motto of our organisation is '***Vayam Sevaamahe'*** which means ***"We are for service***". We in the association should at all levels and organise programmes like National Skills Enhancement Programmes, Regional Refresher Courses and CMEs for our younger colleagues. We should all aim to make the body more vibrant and active and strive for increasing membership at our levels.

I once again wish the Mumbai Chapter of ASI all the best for the upcoming ASICON 2022.

Long Live ASI !!

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From the desk of Vice President

Esteemed Colleagues,

Greetings from Bhopal.

I hope you all must be watching the academic programs, RRC format has been updated this year feel free to enrich us with your ideas about them. It's also amazing to know that after a long waiting period of three years we will be able to meet in person at Mumbai ASICON. I am sure that your participation is going to make it memorable. I will also seek your support and guidance for the next year. And one more important thing is forthcoming ASI elections, kindly participate in big number to make the democratic body much strong. All the necessary information will be sent to you on your registered email from time to time. And finally the festive season in India has begun have a blessed festive season.

Long live ASI

With best wishes and warm regards

From the desk of Imm Past President

Dear Colleagues,

I am delighted to see the Newsletter of ASI 'SCALPEL' is being published again. With the Newsletter being published it will further strengthen our resolve for academic and social progress and communication.

I wish Dr. Tarun Mittal, Dr. Madhumita Mukhopadhyay and Dr. Rajesh Prajapati, the new Editorial Team, all the best for this exciting newsletter which has several new sections in it.

Jai Hind

Long Live ASI !!

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From the desk of Hony Secretary

Dear Esteemed Members of ASI,

Greetings from ASI Head Quarters!!
I am extremely delighted to know that the second edition of our Newsletter of ASI – SCALPEL is being published by our enthusiastic team of Newsletter committee.

Dear Colleagues, We all have witnessed the most unpleasant last 2 years due to pandemic situation. But as all of you know "Change is the only constant in life; But resistance to change is always the biggest obstacle". Hat's off to the Principle office bearers of ASI as well as to entire Executive Committee of ASI who easily overcame that obstacle and we all got adapted ourselves to online platform be it - National Skills Enhancement Programmes, Regional Refresher Courses and previous two ASICON's 2020 & 2021 which were organised by ASI Head Quarters with equal vigour and enthusiasm reflecting exemplary team work which only shows that "Leadership is all about translating vision in to reality".

This year we are all set to have first physical ASICON 2022 after a gap of 2 years that too in the City that never sleeps, never fails, dreamers paradise and citizens pride – Mumbai. The 82nd annual conference of The Association of Surgeons of India will be held at Mumbai from 21st to 24th December 2022. An unwinding academic feast, always sought after by all the surgeons of this country awaits you to de-stress, in the background of learning and teaching what we are best at – Surgery. Nothing gives me more pleasure than to warmly welcome all of you to this scientific extravaganza coupled with best ever hospitality.

I heartily congratulate the editorial team comprising of Dr. Tarun Mittal, Dr. Madhumita Mukhopadhyay and Dr. Rajesh Prajapati for this ever exciting second edition of ASI newsletter SCALPLE on behalf of ASI Headquarters.

Long live ASI.

From the desk of Hony Treasurer

Greetings dear fellow members,

As you are aware that ASI is letting no stones unturned for improvements of surgical healthcare all over the country. Under able guidance of our dynamic president Dr G Siddesh the association is progressively and effectively working on its agenda including academics, social welfare, SSS etc. In academics under the able leadership of Director of Academics Dr. Santhosh John Abraham the association has completed NSEP and now RRC is going on which are equally appreciated by residents as well as members.

Though past years have taken a toll on most of the activities of ASI but the association has strived hard and kept academic activities going on. The platforms have changed from physical to virtual culminating in virtual NSEP, zonal RRCs and even our national conferences were held on the digital platform. All this was made possible by enthusiasm of our National Executive body and definitely all the members of this association.

Now once again the ASI is going to organize its annual conference ASICON 2022 on physical platform at Mumbai this year. As always the conference will be an extravagant academic scientific and cultural feast.
I encourage all the fellow members to get registered and present their work on this national platform after a hiatus of two years it will be a physical conference and will be able to meet soon.

Long live ASI !!

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From the desk of Director, Academic Council ASI 2022

Dear Esteemed members of ASI,

Greetings from the Academic Council of ASI. We are at the thrust of meeting physically after a log gap of 3 years for the Annual National Conference - ASICON 2022 at Mumbai from 22nd to 24th December 2022.

ASICONs had undergone huge metamorphosis from just a “mela” spanned over 5 days with predominant fun and frolic, now to a platform to show case the best of Indian Surgery in 3 days. What used to happen in 15 parallel halls where multiple repetitions of the same faculty with the same topic have moved to just 5 halls where no faculty is repeated for a second time. The membership of ASI had grown from 15000 in 2015 has become more than twice in less than 7 years- with the kind of pace of growth, we should be optimistic to become the biggest professional body in the world soon.

Content of ASICON include Orations, Lectures and plenty of panel discussions on specific focused topics which will be addressed by the experts in the field to come out with contemporary conclusions. With the exponential growth in knowledge, development of various technologies in areas of diagnosis to therapy and huge invasion of radiology and endoscopy into the treatment options, the surgeons are challenged to accrue different kind of skill sets to remain in the run for their survival and emergence as experts in the field. ASICON tries to makes this as a realizable platform in a short span. Further development of craftsmanship depends on the choice and effort of each individual. It is certainly a daunting task to balance the expectations of many and what is achievable as a ground reality. It is extremely gratifying to be part of this process as an individual and a member of ASI. We have a galaxy of talents spanned across the country in all the different aspects and field of surgery. Some are with an extra gift of expression but Academics in ASI have always looked above this in making the exposure.

The finals of ASI TYSA 2022 to identify the best resident in India for the current year will also happen during this conference. Every day we have 4 hours of clinical teaching with various components with the best of our surgical teachers in the country.

I am extremely glad to note the enthusiasm of the editors behind the “newsletter” and its massive acceptance amidst the membership of ASI. The Organising team at Mumbai is making huge efforts to make ASICON, the most memorable event. Your presence can make it a reality. Please register for ASICON 2022 in large numbers. Hope to see you at Mumbai.

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National Skill Enhancement Programme (NSEP) 2022

- The 7th NSEP Programme conducted on 16th March 2022 – Surgical site infection
- The 8th NSEP Programme conducted on 23rd March 2022 –Dressings & Bandages
- The 9th NSEP Programme conducted on 30th March 2022 –Surgical Nutrition
- The 10th NSEP Programme conducted on 6th April 2022 –Cytology for surgeons
- The 11th NSEP Programme conducted on 13th April 2022 –Deep Vein Thrombosis
- The 12th NSEP Programme conducted on 20th April 2022 –How to select a thesis in Surgery
- The 13th NSEP Programme conducted on 27th April 2022 –Tuberculosis
- The 14th NSEP Programme conducted on 4th May 2022 –CT Scan for surgeons
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National Skill Enhancement Programme (NSEP) 2022

- The 15th NSEP Programme conducted on 11th May 2022 – Region based supplements to Surgery
- The 16th NSEP Programme conducted on 18th May 2022 – Dispelling in Myths in care after abdominal Surgery
- The 17th NSEP Programme conducted on 25th May 2022 – Research in surgical sciences
- The 18th NSEP Programme conducted on 1St June 2022 – Shocks for surgeons
- The 19th NSEP Programme conducted on 8th June 2022 – Paediatric Surgical Emergencies
- The 20th NSEP Programme conducted on 15th June 2022 – Evaluation in Jaundice
- The 21st NSEP Programme conducted on 22nd June 2022 – Career options in surgery
- The 22nd NSEP Programme conducted on 22nd June 2022 – Career options in surgery -Glimpses of Surgical Career in the United Kingdom
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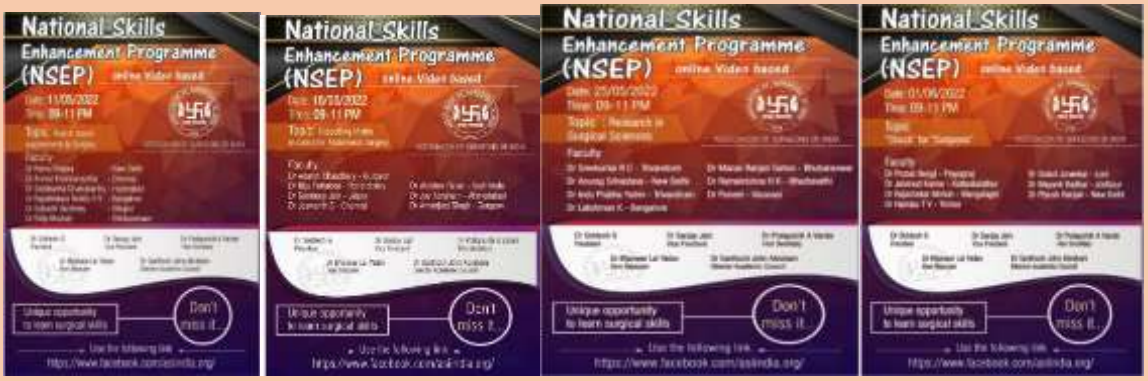

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ASI & Various Chapter Activities

President Dr. G. Siddesh invited to attend 39th Annual Conference of Madhya Pradesh State Chapter - 11– 13 March 2022.

Honorary Secretary Dr. Pratap Varute invited to attend Annual Conference of Poona Surgical Society (PSSCON 2022) on 12 March 2022 and delivered Dr. Mrs. M J Mehta Oration

President Dr. G. Siddesh & Vice Presdient Dr. Sanjay Kumar Jain attended Annual Conference of Chhattisgarh State Chapter (CG ASICON 2022) on 17th April 2022 at Bhilai.

President Dr. G. Siddesh invited to attend Foundation Day Function of NAMS on 21st April 2022 at New Delhi.

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President Dr. G. Siddesh invited & honoured during 19th Annual Conference "OSSICON 2022" of Obesity & Metabolic Surgery Society of India (OSSI) held at Sheraton Grand Hotel, Bangalore - 21st April to 23rd April 2022.

President Dr. G. Siddesh invited to attend Kolhapur Surgical Society 2022 Conference at Hotel Sayaji, Kolhapur on 23rd & 24th April 2022. President Dr. G. Siddesh delivered Dr. P.B. Bhadre Oration.

President Dr. G. Siddesh invited to attend Annual Conference of Maharashtra State Chapter (MASICON 2022) on 28th - 30th April 2022 at Pune.

President Dr. G. Siddesh attended 9th Annual Conference of Haryana State Chapter of ASI (HASICON 2022) held on 7th & 8th May 2022 at Faridabad.

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Executive Committee Meeting of the Association of Surgeons of India held at Virtual Platform on 29th May 2022 with large number of attendance. Many important decisions were taken.

Dr G Siddesh, President ASI formed 3 member committee for the circular received from NMC and the Meeting held with Committee Members on 6th June 2022

President Dr. G. Siddesh invited to attend 45th Annual Conference of Kerala State Chapter (KASICON 2022) on 18th & 19th June 2022 at Trivandrum.

Surgical Society Bangalore celebrated Doctors day on 25th June 2022. President ASI Dr. G. Siddesh invited to attend the meeting as Chief Guest

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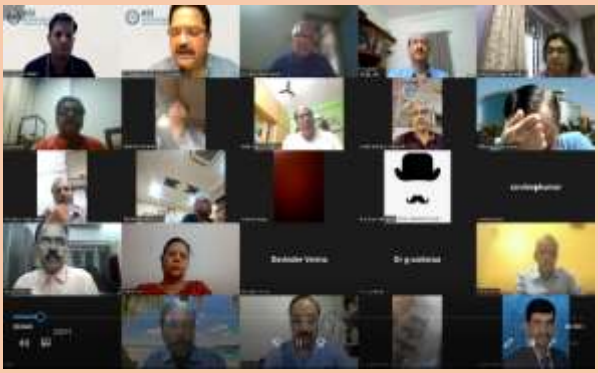
ASI Social Service camp at Swami Vivekanand Charitable Hospital, Dharmawala, Dehradun on the 26th of June, 2022 under Uttar Pradesh State Chapter of ASI

National Executive Committee held on 30th June at Zoom platform for Ratification of new Membership



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A case of Injury Face

Authors: Dr (Col) Ashim Banerjee, Dr. V Lakshman, Dr. Geeta Krishnana
Kothari Medical Center, Alipore, Kolkata

Summary: A case of blast and bullet injury face is presented

History

A 54 year old man from Bhagalpur (distance 370km), presented on 7 October 1998, with the history that some miscreants threw a bomb/cracker on his face on the previous day which burst inside his mouth. He fell down unconscious, bleeding profusely, was taken to a Nursing Home, where the bleeding was stopped and he was advised to be taken to Kolkata immediately.

On arrival, he was in great distress. The face and front of neck were grossly swollen, with wounds in the right side of upper lip and nose. He had difficulty in opening the mouth, which made detailed examination difficult. He could not swallow even fluids, could only mumble and was dribbling blood stained saliva. There was no breathing difficulty or external wound in the neck. X-ray revealed 4 fractures in the mandible with gross displacement, and 3 cm loss of bone in the left side of the body of mandible. CXR showed a 5 cm long triangular foreign body with the sharp edge downwards, in the root of the neck, just behind the sternum. He was hypertensive but non diabetic.

The next day, he was explored but non diabetic turned out to be a bullet, firmly embedded into the posterior surface of sternum. It was removed by a 'T' shaped incision. The relatives agreed that he was initially shot, before being attacked by a bomb (cracker). Examination of the mouth showed gross soft tissue trauma in the floor of the mouth with splitting of the tongue in the midline, up to the posterior third, and splitting of right upper lip and nostril. Wound toilet, hemostasis, and repair of the tissues in layers was done. The bones were fixed with 4 plates and 2 circum-zygomatic wires. Loose fragments of bones were removed from the path of the bullet. There was mucosal loss in the right side and in the wound of entry of the bullet. Postoperative airway problem was expected. Tracheostomy was decided against, as the path of the bullet was ensuing tissue damage, lay in front of trachea. A soft endotracheal tube was retained. Nasogastric tube feeding was started, after recovery from anesthesia.

The postoperative period was very stormy. He became extremely restless, violent and uncontrollable. O2 saturation fell. He had to be paralysed and was placed on a ventilator. There was gross swelling inside the mouth and the circum-zygomatic wires, which were pressing on the swollen tongue, had to be removed. Attempts to wean him off the ventilator early, was not successful.

On 12 October 1998, under general anesthesia, 8 pins were passed (2 into each frontal and zygomatic bones and 2 into each side of mandible), for external fixation. These were connected by rods through universal joints. The plan was to bring the displaced bones into correct position, by repeated manipulation of the fixators, under fluoroscopic control. But this could only be started after 4 days, after the patient was taken off the ventilator. After 2 more days, the endotracheal tube was removed in the operation theater. Keeping tracheostomy set ready, in case of any airway problem. After another 6 days, the exposed plate on right side was removed and the wound could be closed. A check flap was transposed to cover the wound of entry of the bullet. He could be discharged on 28 October 1998 (3 weeks after admission), with periodic review and adjustment of the fixators. After another 3 weeks, when he was able to swallow, the nasogastric tube was removed.

The external fixators were removed on 7 December 1998 (2 months) after clinical union of the fractures, and he returned to Bhagalpur. He returned for review after 3 months, when a denture could be fitted. The cosmetic appearance was satisfactory. He could open the mouth fully. There was no dribbling of saliva. Speech was clear. He still had some difficulty with hard food and complained of occasional pain.

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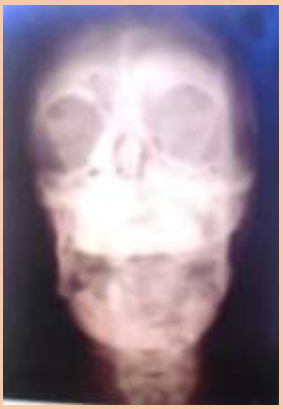
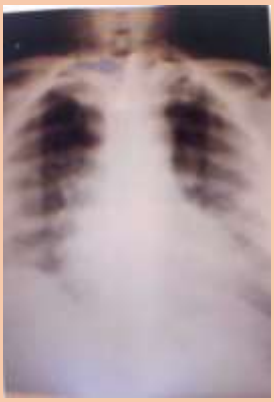
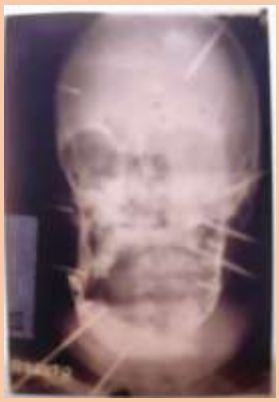
The aim of treatment in this case was to save life by removal of the bullet lodged in the back of sternum, that could have caused damage to the great vessels, prevent airway obstruction following gross soft tissue and bony injuries of the mouth, and preserve function, as far as possible.



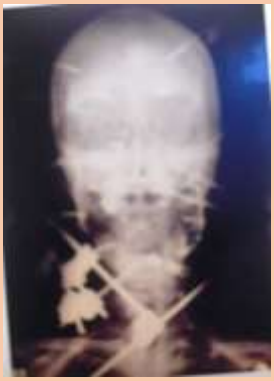
X-ray on admission



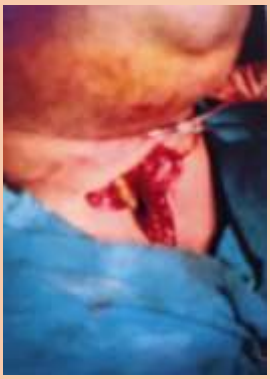
CXR-Arrow points to FB



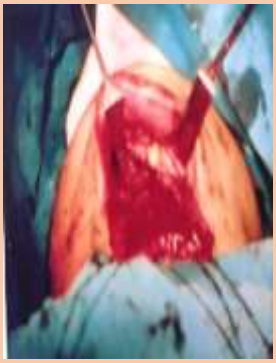
Xray-after passing pins



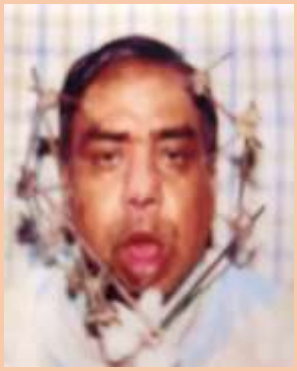
After manipulation



Bullet exposed by T-shaped incision



Oral cavity after wound toilet



On discharge

Final review

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Primary anorectal malignant melanoma with liver metastasis: a rare case.

Authors: Ashok Hegde[1] Anand Ignatius Peter[2] Anand Bhandary Panambur[3]
[1]Professor, [2]Associate Professor [3]Senior Resident, Department of General Surgery,
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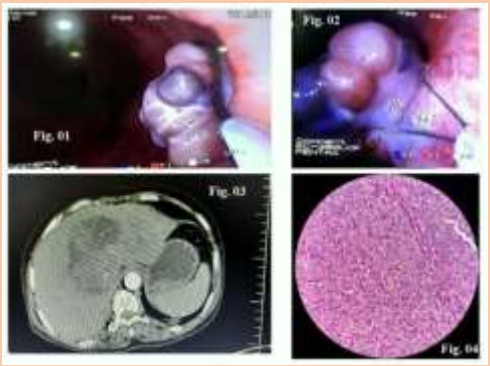
ABSTRACT: Primary Anorectal Malignant Melanoma (PARM) is a rare and aggressive tumor with incidence of 3% of all anorectal cancers. The tumour may seem like adenocarcinomas, small cell carcinomas, or sarcomas histologically, yet it looks like hemorrhoids grossly. The prognosis is poor, with a median survival of only 24 months and a 5-year survival rate of < 10%. The majority of patients die as a result of complications related to metastasis. We are reporting a case of 57year old woman with PARM with liver metastasis.

KEYWORDS: Primary Anorectal Malignant Melanoma, Rectal Bleeding, Liver metastases, Poor prognosis, Colonoscopy.

INTRODUCTION: Primary Anorectal Malignant Melanoma (PARM) is a rare and aggressive tumor with incidence of 3% of all anorectal cancers. [1,2] Despite the fact that the anorectal region is the third most common site for melanoma after the skin and the retina, it only accounts for < 1% of all primary melanomas.[3,4] Local symptoms such as rectal bleeding and altered bowel habits are common in patients. The prognosis is poor, with a median survival of only 24 months and a 5-year survival rate of < 10%. The majority of patients die as a result of complications related to metastasis.[5] Due to rarity of this entity there is no consensus on treatment. Favorable cases can be taken up for surgery. [2] We report a case of 57year old woman with PARM with liver metastasis.

CASE REPORT: A 57 year female with complaint of painless rectal bleeding with vague upper abdominal pain for 2 months was referred to General Surgery department of our hospital. Rectal examination revealed a 3cm bleeding polypoidal growth, 2cm above the dentate line. Colonoscopy showed a polypoidal growth in the anorectal region with infiltration. (Fig. 1 & 2) Polypectomy was performed. Histopathology confirmed the diagnosis of Primitive Malignant Melanoma. (Fig. 04) IHC showed HMB-45 +++, S100 ++ Negative Wide Spectrum Cytokeratins and Ki-67 80-85%. CECT revealed an ill-defined heterogenous hypodense lesion in the segment IV showing peripheral enhancement in arterial and washout in portovenous phase with multiple enlarged portahepatis, celiac and para-aortic lymph nodes. (Fig .03) Oncologic multidisciplinary team validate a palliative chemotherapy with oral temozolomide 200mg 14days every 28days. Patient refused for chemotherapy and opted to avail Indian system of medicine. Patient was lost in follow-up.



DISCUSSION

AMM is a rare type of melanoma, with a poor prognosis. Anorectal melanomas represent less than 1% of all melanomas and less than 0.05 – 4.6% of all malignant tumors of the anorectum. The incidence increases with advanced age in both sexes and at all tumor sites. In general, the 5-year survival rate is low, being only 6%to 22%. [1,2] The tumour may seem like adenocarcinomas, small cell carcinomas, or sarcomas histologically, yet it looks like hemorrhoids grossly.[6] The symptoms are quite vague, with bleeding being the most prevalent complaint. From a tiny pigmented lesion

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to an ulcerated mass, the physical appearance varies. PARM, which is made from melanocytes in the dentate area, is implanted on both sides of the dentate line, hence the term "anorectal." Patients without lymph node metastasis have a survival advantage with a 5-year survival rate of 20 versus 0% in patients with metastasis. Survival of patients with recurrent or metastatic disease is <10 months.[5]

DISCLOSURES

Conflict of Interest Statement
The authors have no conflicts of interest to declare.
Funding Sources
The authors did not receive any funding.

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WITH MALICE TOWARDS NONE AND NULL

"Thou Stiketh closer than a brother"

Author: Dr Rupnayan Goswami, Honorary Secretary, The Assam State Chapter of ASI

"Swaraijya is my birth right....." Yes, only four simple words, yet what a power it wielded. During our freedom struggle this phrase of Lokamanya Bal Gangadhar Tilak induced a surge of nationalistic fervor in the heart of the Indian youth.
There are many instances where a single-liner changed the destiny of a person or stimulated people to take a plunge into the welfare of their country or mankind. Similar effects were produced in John Fitzgerald Kennedy's famous inaugural Presidential speech in 1961, while appealing to his countrymen...."ask not what your country can do for you, ask what you can do for your country". Such a singular event occurred with myself which gave a direction and meaning to my life. The feeling is indescribable today, divine, elevating to a heavenly bliss. Gray mater deceives me today as to the exact date but that it was the night prior to our Second MBBS semester ending examination of "Surgery" was for sure.

Having crossed the first MBBS hurdle affords one a great sense of self-confidence and add to it the opportunity of adorning of thy neck with the stethoscope, coupled with the slow and steady strides amidst the wide-eyed crowd in the wards, catapults one out through the world. It is no wonder one doesnot realize the passing of a whole six months till one fine day you are accosted with a "wicked" notice announcing the arrival of semester examination the very next Monday. You donot know where to start with. You madly scramble through the notebooks for the lectures notes but find out for the first time in your life that one had scribbled only the heading of the topic, no more no less, in one whole single page of "fool's"scape paper ! Then only does it dawn upon the holy idea that books are the only way to salvation. What can a poor and fun loving chap do but to pull out the brand new "Surgery" text book out of the shelf with a habitual deep "sighing" sniff. Now this ritual of sniffing the new book when opened for

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the first time, my naughty-buddy friends may argue as something in myself relating to a bovine genetic penetrance. But I can assure you that the aroma of the index book does produce a sense of belonging, with the lingering fragrance producing an ever-lasting loving intimacy. The opening page adorning a sinuous and tendrilled artistic signature declared the proud owner as Rupnayan. I had the least idea what "Surgery" might be except that it was something to do with opening up the body with a scalpel. But what followed after that, I had never ventured to think and also didnot feel the need for it. Anyway the topic was an "out of the way" kind; not the standard diseases one usually relates to General Surgery like Appendix, Gall Bladder, or Hernia. "Infection of the hand" it was. I remember the topic as well as the class vividly as it was made so interesting by late Professor Tanka Bora sir, professor of Surgery, for whom humor was his forte. So, clutching onto the straw, I lazily opened the said chapter. I was with a pessimistic and "weak" frame of mind (as the fan of Wodehouse would agree) when I started, and slowly began with the heading....
"The Hand" and then the sub-heading...."Infections of the hand". As I sailed through the first page intuition told me that I was embarking onto something unusual. There was something wrong about the book, but could not understand what it could be. For, I could understand every sentence of it and every sentence seemed to make practical sense. I got upright, looked at the book with grave suspicion for, I didnot remember such an easy book in my medical career till then. Gray's anatomy, Cunningham's, Harper's.....the fright was yet to fade away. Thus aroused my curiosity and I delved deeper into it. I could suspect the surge of a feeling inside me, to savor as much as of it before the stream dries up. And hence was almost "huffing and puffing" when the stage to operate upon the patient had reached. The language was so lucid, so crisp and easily digestible, thoughts flowing so freely, that it threw me into a sort of reverie where I imagined the patient- his hand swollen and turgid, face expressing extreme agony. The principles laid down were so reasonable and practical! By the time I completed reading the chapter, I had administered IV antibiotics, opened up his abscess, let the pus out, did the dressing and carefully "elevated" his forearm; else would it not cause increase in its swelling with ensuing throbbing pain?! Absolute common sense, what else! I could feel the relief the patient experienced and closed the book with a deep sense of satisfaction that I could do something for the hapless fellow.!

Gray's anatomy- simply profound, Cunningham's- mind boggling, flow charts of Harper's- amazing. But what a book this is ! Simplicity to the core, hardcore practical with no-nonsense approach, knowledge-wisdom-common sense pervading each and every word-phrase-sentence, empathy-sympathy-humane approach to every surgical malady, high literary value, application of scientific methods in the most artistic way possible, simple living high thinking attitude, tremendous humor, brimming with tips and tricks of the trade, historical sense.....
praises, adverbs, adjectives, exhausted in my vocabulary to express, explain or rather introduce the book to my esteemed readers today. Naturally the experience made one inquisitive to know the personality behind this great book. I donot remember where I heard the adage "one who sees from the beginning has the best view". So, I started with the cover of the book. Since then, till today I always ask my students as to the name of the book. But like myself, maximum students profess ignorance towards it. Those who lamely pronounce "Love and Bailey", though colloquially correct yet are morally (will come to that another day) incorrect as far as the syntax was concerned for it is written exactly in the reverse order, "Bailey and Love's". In fact the book starts with these two words that too exactly in that order, not less than "four times" starting from the spine, front cover, opening page and inside front cover before starting of the texts. Really interesting how our brain overlooks the most common of things. But mind you, this is the 20th edition (1988) of the book I am referring to. Still the actual name is not yet complete, for, it is "Short Practice of Surgery", or "Bailey and Love's Short Practice of Surgery" to be precise. No wonder I fell in love for the book that very instant. That was the day I understood the practical meaning of this discipline called Surgery. I realized where my destiny lies, and what will its nature be. Surgery and nothing else but surgery will it be! And there was no looking back since then. Divine providence blessed me with this holy association. The book somehow reminds me of a passage from Mahatma's interpretation of the Gita. I cannot produce ad verbatim, only the flavour lingers today....Gandhiji said that his life was full of misery and sufferings and whenever a state of despondency ensues, he could always find a piece or sloka here or there in the Gita, which could pull him out of the gloom. A surgeon's life is fraught with danger, uncertainty, frustration. Leafing through the book, does often in such gloomy moments, one comes across a line, an aphorism, or a time-tested advice which elevates the mood and restores one to his self.

The book clings to my bosom like the lovely infant to his loving mother. I continue to derive inspiration, the zeal to furtherance my surgical pursuits; it is only for "thyself" that this wonderful world of "Surgery" unfurled unto myself.....

O my dear Bailey
"Thou Stiketh closer than a brother"

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Case Report: An interesting case of redo bariatric surgery

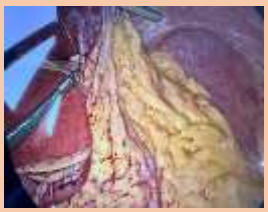
Author: Dr. Digvijaysingh Bedi, Bariatric & Metabolic Surgeon, Director Hope Obesity Centre, Ahmedabad Gujarat

Case Summary: A 50 year old female approached our bariatric team for weight loss with chief complaints of rapidly increasing weight since 1 year, breathlessness on exertion since 6 months and body aches and bilateral knee pain since 3 months.

Past History: Patient had undergone Laproscopic sleeve gastrectomy 4 years back. She had lost good weight in her first year from 104 kgs to 78 kgs and her comorbidities like Hypertension was resolved too. From 2nd year onwards her weight loss stopped and she gradually started gaining weight from there onwards. She got her hypertension back and 2 years back she was diagnosed with Diabetes as well and was put on OHA.

General Examination: Patient looked very anxious and clearly was in depressive state. Weight: 115.8 kgs , Height: 155cms. BMI : 48.2 (Morbid Obesity grade III). Systemic Examination: Abdominal system: Obesity +++. Respiratory System: Normal. CV System : Normal. She underwent detailed investigations like blood tests & radiological investigations and positive findings included: HBa1c of 7.4 FBS: 148 Mildly raised liver enzymes. USG showed grade 2 Fatty liver. **Plan:** We decided to do Revisional Bariatric Surgery looking at her weight regain and onset of co-morbidities like HT and DM.

Operative Procedure: Laparoscopic approach was taken. Excessive adhesions were removed of previous surgery. Complete dissection of the neo greater curvature of sleeved stomach dissected. Large redundant fundus of stomach was found probably left during first surgery. Fundectomy was done using endostaplers and staple line buried. Stomach stapled and cut at the incisura. Whole small bowel from Ligament of Treitz to IC junction counted and 250cm jejunam marked and enterotomy made. Antecolic retrogastric Gastro jejunostomy done using endostaplers and enterotomy was closed with vicryl 2-0. Methylene blue leak test was done and found to b negative. Hemostasis checked and closure done. Post- operative recovery was uneventful and was discharged on 2nd post-op day and is now being followed up and managed by our Bariatric dietician and is following the post surgical protocols. First follow-up on 10th POD showed a weight loss of 4 kgs. At one month she is having a steady weight loss of 6.2 kgs with early signs of resolution of co-morbidities.



Dense adhesions

Redundant fundus excised

Creating gastrojejunostomy

Hand sewn enterotomy closure

Conclusion :

Though Sleeve Gastrectomy(LSG) apparently looks an easier procedure if not done in a technically sound manner it can cause uncomplete weight loss or weight regain. Complete removal of all the fundus is an important step in LSG. Good follow ups of the patient is of utmost importance. Redo surgeries are always technically challenging and more prone for post-op complications like leaks and bleeds. Long segment bypasses after redo surgeries can lead to nutritional deficiencies hence need good check on patients progress.

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Jain Point: First blind Entry Port for Laparoscopic Cholecystectomy

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Abstract: Non umbilical entry points are safe alternatives in cases with previous surgeries. The various entry points described so far in the literature have one or the other limitations like hepatomegaly, splenomegaly, portal hypertension, gastric or pancreatic masses, previous gastric or splenic surgery, presence of left upper quadrant adhesions, periumblical adhesions and bloated stomach. Here, we describe a case where the patient of acute cholecystitis with a history of exploratory laparotomy for intestinal obstruction, was taken up for laparoscopic cholecystectomy. Due to the presence of large midline incision extending upto the umbilicus, we chose non umbilical port in left paraumblical region for creating pneumoperitoneum and as first 5mm port which is called the Jain Point.

Case report: This is a case of a 41 year old lady who presented with history of multiple episodes of acute upper abdominal pain, associated with nausea & vomiting. There was no history of jaundice, fever, dark colored urine or clay colored stools. On examination tenderness was present over right upper abdomen with a positive Murphy's sign. Ultrasonography showed gall bladder with thickened wall with a large calculus measuring 1.35cm impacted at neck. Blood investigations showed -Hb% - 10.5gm%, TLC- 12,000/mm3, DLC – N84L14E0M2, Platelet count- 1.5 lac/mm3, SGPT- 36 IU/L, SGOT- 35, IU/L, ALP- 94 IU/L, KFT- Normal. She had a past history of exploratory laparotomy 10 years back for Intestinal obstruction followed by anti-tubercular treatment for 1 year.
Koch's abdomen is one of the commonest cause of abdominal adhesions (Intestinal) leading to intestinal obstruction. Due to presence of midline incision, extending upto the umbilicus and history of koch's abdomen we were looking for an alternate entry point, as, by moving upwards towards Palmers or Lee Huang point we would get closer to the viscera such as stomach, spleen and liver. A novel non umbilical entry point, Jain Point which has been described by Jain et al(1), seemed a viable option in this case to avoid the adhesions of previous surgery and to avoid injuries to viscera (Stomach, Spleen, liver). So we chose the Jain Point as a port of entry for creating Pneumoperitoneum. Surface anatomy of Jain Point is if we take a point 2.5 cm medial to anterior superior iliac spine in horizontal plane and from this point a line is drawn vertically upto the level of umbilicus. This point did not become redundant after insertion of Veress needle and first blind port entry. We took additional advantage of this point for thorough inspection of abdominal cavity, take stalk of adhesions and optimize other working ports according to mandate of the case.

Under general anesthesia, pneumoperitoneum was created using Veress needle introduced through Jain point and a 5 mm trocar placed at the same point. Laparoscopy was done using 5mm telescope. Adhesions were seen over whole previous incision line, while no adhesions were seen around Jain Point, thus the same was converted to a 10 mm optical port. Under vision another 10 mm working port placed in epigastrium avoiding adhesions. A 2.5 mm alligator forceps introduced through right hypochondrium. Adhesiolysis was done. After retracting the gall bladder using microalligator forceps, the hepatocystic triangle was defined and Calot's triangle was dissected out. Cystic duct & artery were skeletonised and critical view of safety was achieved. Cystic artery & cystic duct were doubly clipped & divided. Gall bladder was dissected off from gall bladder fossa using Harmonic ACE and specimen was removed by 10 mm port in bag. Hemostasis was achieved. Both the 10mm ports were closed using Vicryl 2-0. In this case Jain point port became the optic port and 10 mm epigastric port became the working port, while the surgeon stood on the left side of the patient.

Fig 1: 5 mm entry port at Jain point

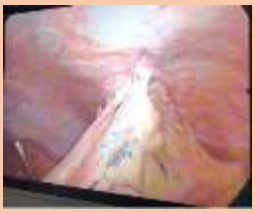

Fig 2: Adhesions around umbilicus 5mm Jainpoint port seen free from adhesions

Fig 3: Gall bladder being held by 2.5 mm Micrograsper

Discussion: Non umbilical entry points are the preferred points of entry in patients with previous surgeries with midline scars reaching upto or above the umbilicus and in upper abdominal scars. Most commonly used point in such situations is the Palmer's point which is 3 cm below the left costal margin in midclavicular line(2). Another alternative that has been used more recently is the "Jain Point" located 10-13 cm lateral to the umbilicus on a vertical line drawn 2.5 cm medial from the left anterior superior iliac spine(3). The ideal entry point should aim to avoid injury to major retroperitoneal vessels, abdominal viscera, adhesions of bowel and omentum (4). Jain point lies at the level of umbilicus at L4 level on left

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side, 10-13 cm away from midline depending on body habitus and BMI of patient. Its location away from midline safeguards any risk to major retroperitoneal vessels, and midline adhesions due to previous surgery. Its location at level of umbilicus(L4) poses no risk of gastric injury as the bloated stomach almost never descends below the level of L1. It is a safe entry point in cases of Hepato-splenomegaly, Portal Hypertension, left upper quadrant surgical scars and upper quadrant gastro-pancreatic masses, all these are contra-indications of Palmer's Point. This novel point, being lower, at level of umbilicus and much lateral to Palmer's point can be safely used in all contra-indications of Palmer's point. In comparison to Palmer's point Jain Point can be more easily used as operating port throughout the surgery (5). It has been proposed as an alternative for patients with a previous Chevron incision where, left upper quadrant entry was complicated by adhesions There has been a case report where Jain Point entry is made in a case of large Chevron incision done earlier for liver abscess, in this indication of large upper abdominal scars Jain Point came as a savior, and in surgery they found that loop of bowel was adherent at the Palmer's Point (6), whereas Jain Point entry point was free of adhesions. In 1993, the Lee–Huang point was developed as the site for insertion of the primary trocar which is located midway between the xiphoid process and the umbilicus. Relative contraindications to the use of the Lee–Huang point include a previous midline vertical incision, hepatomegaly, splenomegaly, and intestinal obstruction (7). Jain point seemed to be a more viable option of entry port in the cases of previous abdominal surgery. Mulayim B reported a case of direct trocar entry from Jain point (left lateral paraumbilical port) in a 50-year-old female patient, who had two cesarean sections with a pfannenstiel incision, one open cholecystectomy with a Kocher incision, and a lumber disc operation and found that there were no adhesion under Jain point but there is adhesion under the cholecystectomy scar till to the umbilicus. There are no entry-related, intraoperative, or postoperative complications with the use of direct trocar entry. He concluded that direct trocar entry from Jain point in cases with previous surgeries is potential alternative to existing entry techniques (8). Being at level of umbilicus it avoids adhesions of upper abdominal scars (9). Its location on left side is favourable as majority of abdominal adhesions are present on right side due to previous appendectomy, previous adhesions due to abdominal tuberculosis, previous midline or right paramedian vertical scars.

In the retrospective study describing this entry method ,there were no significant entry complications in 624 patients with prior abdominal surgeries(10). It is also preferred in cases of hernia repair using a large mesh where Palmar's point become relatively unsafe due to its medial position. There were no entry related complication through Jain Point even in thin patients (BMI <18.5kg/m2)(11). Apart from anatomical location the technique of insertion is also very simple making For creating Pnemoperitoneum through Jain Point,operative table is held in horizontal position and a small 1-2 mm nick given just enough for verres needle entry.Verres needle is then inserted perpendicular to the abdominal wall in a vertical direction irrespective of patient being obese, average weight or thin. The abdominal wall is not lifted and there is no change in direction of veress needle. This makes the insertion easy and simple and can be performed even by novice surgeon.(3)

Conclusion: In the current era of minimal invasive surgery where everyone is reducing port size and the number of ports, Jain Point offered an extra advantage of using it as entry as well as working port for laparoscopic Cholecystectomy.

Non umbilical entry points are safe alternatives in cases of previous surgeries with midline scars. In cases where Palmar's point, Lee Huang point, Hasson are relatively unsafe as in upper abdominal masses, upper abdominal scars, splenomegaly, distended abdomen: Jain point offers a safe entry approach. This is a novel point as it works on the concept of taking the entry far laterally away from the umbilical adhesions and lower than Palmer's point, thereby avoiding the adhesions of upper abdomen.

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100 days of patience; a tale of hope and resilience

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Mornings rounds on Sundays are a little earlier than weekdays in my surgery unit, and the chief of surgery leads the rounds. It was another Sunday morning rounds, non-duty residents were dressed in t-shirts and casuals with smirks on their faces and on-duty residents were hustling to post an emergency case in their OT outfits. Rounds started from HDU (High dependency unit) and progressed to the postop cubicle, as we approached one of the ward cubicles, we were greeted by a 15year old boy with a broad smile that created a groove on his cheeks. 'Flex your power" said our chief in his upbeat tone. The boy followed suit and flexed his biceps with confidence as the residents chuckled. "Click a photograph with him and discharge him today" our chief sounded pleased with himself and all residents. After the rounds, residents were happy to see him get discharged from the hospital. Everyone shared their experiences while managing his illness. I could only see the pride in all our faces. Three and half months earlier in early February, on a routine OT day, I was sprinting towards the canteen to quickly grab food after finishing a case when I saw a colleague rushing towards OT. "We are operating a case of abdominal tuberculosis with perforation in OT 1" almost blurted in a breathless voice, as he walked past me, I didn't bother him by enquiring further about the patient. I quickly finished my lunch and got scrubbed for the next case, an hour and a half passed. After the case got over, I checked on the emergency case in OT1, it was a 15year old boy being operated on. "There are 3 perforations in the bowel and the whole intestines are clustered" senior resident sounded worried about the findings. "We will insert drains and put a bag to cover the abdomen," he said as other residents nodded their heads in agreement. I could only think of an uncertain prognosis for this boy as I walked out of the theatre. The next morning rounds, when we saw the boy, he was lying on his bed in slight pain, while his distressed father was comforting him by stroking his hand over his head. Our chief tried to talk to him, but the boy seemed rather uninterested to respond. "Start him on injectable ATT (Antitubercular treatment)," the chief said, as we walked out of the cubicle. "This child can make it if we spend time on him," he said, reflecting on his abundant experience in managing challenging cases.

In the initial days after his surgery, it was hard to bond with him. Other than crying while changing his abdominal dressing, he wouldn't utter a word. It was challenging to manage his abdomen, as greenish fluid (bile) would soak it in a few hours' time and irritate his skin. His hydration, blood pressure, and body salts would fluctuate on daily basis. Total parenteral nutrition, oral ATT, and oral feeds were started by end of the first week. Despite encouragement, he kept himself on the bed, as a result, he started developing lung infections and pressure sores on his back. In the coming weeks, things got better, and he started moving around. He would speak of his school, friends, and his ambition: "I would be a police inspector one day" he would say. By the end of the fortnight, his chest and sepsis were settled. The main challenge for us was to manage his nutrition, output from the fistulous bowel, and blood salts for the next few weeks. In every round, the chief would emphasize continuing oral ATT, feeds, and TPN. He would ask the boy to flex his biceps to instill confidence in him. Days passed by and his abdominal wound started shrinking, although the output from the bowel continued to be high, requiring intravenous fluid supplementation. Two months after his presentation we were able to localize the exact site of the fistulous bowel. "We should take a call on him, and let's operate him after 2 weeks,", "It's a dicey call, can go either way," our chief said to residents, hoping to restore his bowel continuity and close his abdomen. The same week we started priming him for surgery. He was now a transformed boy and was on the same page with us with positivity and determination to get well.

"He will be on the list this week," the chief said. "You all should pray for him" he further added as we all stood forming a semicircle in front of him near the nursing counter, as we nodded in affirmation. The boy was reoperated 3 months after his first surgery. We all could see the magic of the oral ATT. The intestine which was clustered during the first surgery was now separated with some ease and we could restore his bowel continuity and close his abdomen. He started taking an oral diet 4 days after surgery and improved steadily. 10 days later, on a fine Sunday morning he "flexed his biceps" and left for his home happily in joy. "I think such experiences will never be forgotten" one of my colleagues said while awaiting food in the campus mess. I kept wondering how fortunate I was to be trained by our chief who instilled a sense of hope and perseverance in the boy as well as the residents in dealing with such a complex and challenging case.

Euphoria seeped into me as I drove towards hostel and recalled Victor Frankl
"Man's Search for meaning is not one of horror and despair, but one of meaning and of hope for humanity".

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Pregnancy - A perfect masquerade for bowel mass & laparoscopy a perfect detective- A rare case of huge extraluminal transverse colon myolipoma in postpartum period – a case report

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Abstract: A rare case (**may be the first reported case**!) of Huge Extraluminal Transverse colon myolipoma diagnosed laparoscopically after 1 month of LSCS. At various levels we found this case interesting and thought worth sharing ! Intraluminal lipomas and abdomen lipomas are reported in literature, but a lipoma of size approximately 20*20 cms on the wall of transverse colon without causing obstruction intraluminally which went unnoticed due to pregnancy seems an interesting rare case. Transverse colon GIST during pregnancy as differential diagnosis to this present case is available in literature. Not much literature available for extraluminal transverse colon myolipoma during pregnancy

Keywords: Transverse colon lipoma , subserosal myolipoma ,

Case report : We present a case of 29 year old female P2L2,recently delivered a baby by LSCS 20 days back and complained of abdomen pain and noticed a lump in the abdomen immediately after recovering from LSCS, the involuting postpartum uterus masqueraded the symptoms so was managed conservatively. Since the abdomen symptoms were persisting, she was referred to the surgical department. On the day of examination she had abdomen tenderness and mass of size approximately 20*20 cms occupying the entire right quadrants of abdomen. Mass was mobile and lower border palpable. She was subjected to CT ABDOMEN and reported as possibility of omental infarct. But since her symptoms were not settling , a diagnostic laparoscopy was done (choice of pnemoperitoneum creation was through palmers point with veress needle as the entire abdomen seems to be occupied by the mass and first port was through palmers, then under video guidance left lumbar port and left iliac port at midclavicular line was introduced). **Intra op findings** – dense omental adhesion over the bowel mass , forming a phlegmon and the entire inflammatory mass was adherent to the right side of abdominal wall peritoneum and pelvic peritoneum

Slowly the adhesions were released and the mass was delineated. The mass was found arising from the wall of transverse colon and an intra operative provisional diagnosis of TRANSVERSE COLON GIST was made. So to avoid tumor rupture & spillage a decision of conversion to open resection and anastomosis was planned. A mini laparotomy incision of less than 10cm made, mass delivered comfortably and resected with more than 5cm clearance on both sides and bowel anastamosed in single layer intermittent extramucosal fashion. Patient was started on orals on 2nd day and discharged on 5th day after passing stools. Patient reviewed with The Hpe report with IHC (Demin,SMA,ER,PR positive,HMB45 negative) which came out as transverse colon myolipoma (subsersal).

Discussion: Subserosal myolipoma of transverse colon is not found in literature. This may be the first reported case. Submucosal lipomas and mucosal lipomas per se are rare and literature about them seems very limited. The treatment of submucosal and mucosal lipomas are straight forward either by endoscopic (< 2cm lesions) or surgical resection (> 2cm lesion) [1]. But as in this case the diagnostic methodology and treatment plan though can be approached as other serosal & subserosal lesions (eg.GIST). Pregnancy could masquerade the intraabdominal mass lesions easily, causing diagnostic difficulties.so a high index of suspicion is needed when a patient presents with abdomen pain during pregnancy. Both acute and chronic conditions can be diagnosed and managed laparoscopically during pregnancy and the use of laparoscopy as a diagnostic tool in clinical dilemma cannot be more emphasized and also keeping in mind the effects of CO2 pneumoperitoneum during pregnancy. Every case has a take home message.

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1. High index of suspicion during pregnancy is needed and a heart to do an extensive investigation even during pregnancy seems valid
2. laparoscopy is a great tool during pregnancy for diagnostic and therapeutic purpose. 2. The laparoscopic access to abdomen during pregnancy and large abdomen mass though pose a great deal of challenge, with meticulous details and necessary skills the benefit to the patient is paramount. 3. laparoscopy gives a faster diagnosis and more often faster algorithm to go forth about the case. 4. In this case, laparoscopic approach has given the patient a great deal of advantage right from incision length to almost a scarless healing post operatively and wonderful recovery.

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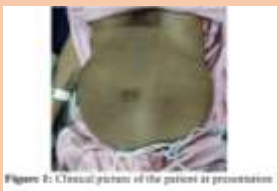
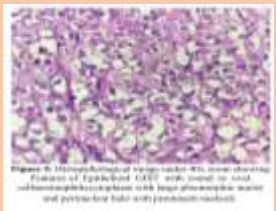
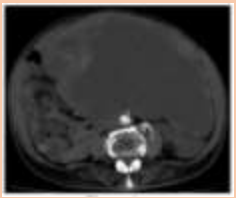
A rare case of large a domino-pelvic GIST

Authors : Siddhant Jayaghosh Kaddu, Navin Kasliwal

Case Report: A 88 year old man presented to the outpatient department with 15 a day history of gross distention of abdomen. He had no any signs/ symptoms of an acute abdomen complained of only early satiety and on examination was found to have a grossly distended abdomen with a dull note on percussion all over it with bilateral pedal edema and bilateral inguinal lymhpadenopathy. To add to the dilemma the USG findings were not confirmative and gave vague differential diagnoses of omental and peritoneal metastatsis from an unknown primary with gross loculated ascites or wet tuberculosis with tubercular peritonitis with pyoperitoneum. Laboratory investigations were within normal limits with a normal total leukocyte count of 5820/ mm3.USG guided ascitic tapping was done along with CECT of the abdomen and pelvis for further evaluation which revealed a thick walled solid cystic mass lesion in abdomen and pelvis measuring 15x26x29 cm approximately, seen infiltrating the anterior abdominal wall muscles, fat planes with urinary bladder, adjacent bowel loops and right external iliac vein appeared indistinct and was seen compressing the IVC. Ascitic fluid sample was hemorrhagic and was negative for malignancy. Exploratory laparotomy was planned and on opening the abdominal cavity a 27 x 15 cm thick walled cystic mass containing approximately 1 liter of hemorrhagic fluid was encountered. It was seen adherent to transverse mesocolon and lesser sac superiorly extending upto urachus inferiorly and was adherent to the retroperitoneum posteriorly. There was no evidence of infiltration of mass into surrounding viscera nor any metastasis. The mass was excised in toto without damaging any viscera or vascular structures. Mass effect and distention of abdomen was relieved immediately and the specimen was sent for histopathological evaluation. Histopathology report was suggestive of Malignant epithelioid cell tumor favoring Gastrointestinal stromal tumor (GIST) with 12-15 mitoses per 50 HFP which is one of the rare types of GIST, part of the urachus excised was suggestive of Malignant epithelioid cell tumor with peritoneal dissemination. After an uneventful post-operative recovery the patient was discharged on Tab Imantinib. To conclude this was one such case of a Gastrointestinal stromal tumor which have myriad of presentations and cause clinical dilemma in diagnosing and treating them.







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What the patient fears and needs to know ? How Surgeon can inform the sick and plan treatment with her his full content

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'Time is Tissue': Nuances of Successful Major Limb Replantation

Authors: Dr. Amiteshwar Singh, Dr. Shruthi Chandrasekar, Dr. Shivangi Saha, Dr. Maneesh Singhal

Summary: Upper limb amputation has devastating effect on patient quality of life, functionality, and possible financial burden. As microsurgical techniques advance, re-implantation or re-attachment surgery can now be performed with great success both anatomically and functionally. A 28-year-old male who had been in a railway accident presented to us five hours after having his right upper limb amputation at the mid-humeral level. While the patient was resuscitated according to ATLS protocol, the amputated part was examined in the operating room for possible replantation. The Brachial Artery and three upper limb nerves were found to be minimally damaged, so replantation was considered after stabilising the patient. Brachial Artery and the three nerves of Upper limb were found to be minimally damaged so attempt was made for replantation once patient was stabilised. Humerus was fixed with an external fixator after necessary shortening, Brachial artery and three veins were anastomosed end to end; Median, Ulnar and Radial Nerves were also coapted end to end while Biceps and Triceps muscles were thoroughly debrided and repaired en-masse. Distal fasciotomy was given to counteract the effects of reperfusion injury. The limb was salvaged after an arduous 12-hour surgery. He underwent plating of humeral non-union 3 months later, once all wounds had healed. Currently, patient is undergoing rehabilitation and is being monitored for recovery of motor function through progression of Tinel's sign. To decide replantation candidacy, we need to take into account injury pattern, patient risk factors, ischemia time, and contamination. Sharp or guillotine amputations have higher chances of success in attempted replantation over crush or avulsion mechanism because of less extensive damage to sharply divided soft tissues. Proximal injuries are prone to increased effects of ischemia as more muscle mass and neuronal tissue are devoid of perfusion. Additionally, this tissue is subsequently exposed to greater oxidative stress and reperfusion injury that can endanger both the replanted limb and patient's life. Having said that, injuries that are distally located are more likely to undergo replantation attempts. Meticulous debridement, vigorous irrigation must be done preoperatively and broad-spectrum antimicrobial therapy intra- and post-operatively can mitigate the deleterious effects of initial contamination on functional outcomes after replantation. Replantation for wrist-proximal amputations should be attempted before 12 h of cold ischemia time or 6 h of warm ischemia time. Therefore, awareness of proper preservation of amputated part is extremely important because referral to a microsurgeon will be useless if preservation is not done correctly. The amputated body part should be wrapped in a moist gauze and placed into a plastic bag, then bag is placed in another bag containing ice. Amputated part should not be placed directly on ice. Direct contact with ice causes significant vasoconstriction, thus the tissue will die faster and make reimplantation harder. It's important to aim for <6 hours ischemia time to allow the best chance of successful reimplantation. Patients who undergo successful replantation report significantly improved outcomes and satisfaction as compared to patients who undergo revision amputation with prosthetic rehabilitation. However, advancement in prosthetic technology holds potential for superior limb functionality, although pain and difficulty of prosthetic use as well as, financial burden of procuring them often results in prothesis abandonment. Limb replantation is currently superior to revision amputation and prosthetic rehabilitation even though major limb replantation may not be a viable option for every patient, thus highlighting the importance of appropriate patient selection.

Fig 1: Image of Patient with Amputated Stump and amputated part.

Fig 2: Immediate Post op Outcome of replanted limb.

Fig 3: Three months outcome of replanted limb with X-Ray of the limb showing skeletal fixation done using plate

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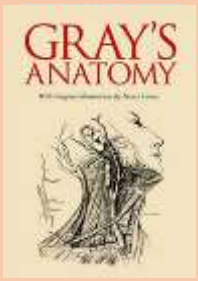
THE OTHER HENRY

The hand behind the familiar illustrations

Gray,s Anatomy, the Bible of all medical students, the human anatomy layer by layer! We all know Dr Henry Gray… the author. But do we know the other Henry ? Gray's bible of medical understanding emerged from his collaboration with another Henry. The artist behind the stage whose illustrations fill the book. Here is the story of Henry Vandyke Carter, the forgotten namesake. Also forgotten is the fact that he devoted most of his life for selfless, pioneering work studying leprosy and mycetoma, as well as providing a number of medical and social services in India.

Henry Vandyke Carter (born 22 May 1831, Hull – 4 May 1897, Scarborough) was an English anatomist, surgeon, and anatomical artist most notable for his illustrations of the book Gray's Anatomy. Henry Vandyke Carter was born on 22 May 1831 in Hull, England, the eldest son of the painter Henry Barlow Carter and mother Eliza Barlow. Soon after, his parents moved to Scarborough, where he grew up. Information on Carter's private life is known in large part due to the diary that his grandmother gave him at age 14 and that he kept for life. In June 1853, Carter became a student in human and comparative anatomy at the Royal College of Surgeons. He worked for John Queckett, the first expert of microscopy, and Richard Owen, one of the best anatomists of the Victorian era. He completed the Bachelor of Medicine degree at the University of London, with honours in Physiology & Comparative Anatomy in December 1854.

The Making of Gray′s Anatomy and Carter′s Contributions: Henry Vandyke Carter′s interest in art gradually leaned toward medicine and in June 1853, he obtained a membership in human and comparative anatomy at the Royal College of Surgeons. Then, he joined as a demonstrator in St. George′s Hospital, London. At the St. George′s Hospital, Carter became associated with Henry Gray who was 4 years older than him. He worked for Gray for his publication titled "The structure and use of the human spleen" initially. Later he was approached by Henry Gray, with a proposal: a new fully illustrated anatomy textbook for students, which he himself created. Carter began work for Henry Gray and in 1856–1857 he drew the illustrations for the now famously illustrated Gray's Anatomy. In 1856, Carter commenced the illustrations for Gray′s book on anatomy. They decided that the book had to be simple, well illustrated and well organized. Innovatively, Carter′s labels were not adjacent to his pictures, distracting the readers to cross-check; instead his nomenclature appeared on the flesh itself. Also, Carter, being a talented artist, made his drawings in reverse directly on wood surface, so that they appeared the right way on the printed page. His excellent style and skilful use of shadows resulted in quality drawings which earlier anatomy books lacked. Carter′s drawings portrayed subjects with their eyes and mouths closed, as if they were anesthetized with chloroform; in contrast to that appeared in other works of anatomy, in which subjects were depicted in tortured postures, as if they were in pain.



First edition and controversy over the title: The first version of Gray's Anatomy, published by Parker, presented Gray and Carter in equal-sized characters names, followed by a caption on a smaller scale with each's titles. Gray was strongly opposed, but publishers, however, considered his contributions significant, as seen in this caption in the introduction to the first edition (1). In the final cover, a compromise was reached: the removal of the Carter title, while retaining an acceptable character illustration credit. The first edition of Gray's Anatomy was published in London in 1858 and Philadelphia in 1859, which was followed by a second in 1860. Also, Gray never gave Carter his share of all the royalties the early editions of the book earned (2). It is thus portrayed that "two very different men of medicine whose unlikely collaboration has launched a masterpiece"

His time in India: Meanwhile, Carter wrote the Indian Medical Service examination and joined the service in January 1858 and moved to Bombay. Carter was employed to the Indian Medical Service in Bombay in 1858 for the rest of his career, where he took up the post of Professor of Anatomy at Grant Medical College, enjoying with satisfaction the good fortune of his book. He served in Satara from 1863 to 1872. Apart from leprosy, Henry Vandyke Carter was the person who named mycetoma as "Fungal tumour". Between 1872 and 1875 he took leave and returned to Europe and worked with visiting researchers of various European nationalities.

Upon his return to India, he was sent to the peninsula of Junagadh and after a short residence he published a report on leprosy in the area. He was eventually awarded the titles of "Principal of Grant Medical College" and "First Physician at JJ Hospital" and was the secretary then president of the Bombay Medical Society, and went off to conduct medical research regarding the most common infectious diseases in poor sections of the

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Indian population, being the first researcher in the Indian subcontinent to confirm the presence of endemic diseases such as tuberculosis, (of which Robert Koch would only discover the pathogen, the "Koch bacillus", in 1892) and malaria.

He worked on Spirillum and relapsing fever, for which he received a Stewart Prize in 1882. During a massive outbreak of famine fever of 1877-1878 in India, Carter shouldered the responsibility of investigating the cause of fever amongst the starving people and labeled it as relapsing fever. He identified Spirillum minus, the spirochete, in blood of the diseased cases, first time ever in India. He postulated that it could be transmitted by inoculation of blood, not only to man but also to monkeys. In the course of this study, he brought to notice the role of spleen in clearing the blood off microorganisms. He was the first to put forth the view that chyluria is due to rupture of lymphatic varices in the urinary tract. Other works of Carter that deserve mention are on the microscopic structure of calculi and parasite of malaria

After thirty years in India (1858-1888), Carter returned to England to settle down in Sarborough. In retirement, Carter was appointed "Honorary Deputy Surgeon-General and Honorary Surgeon to the Queen". He died of tuberculosis on 4 May 1897, at the age of 65. A commemorative plaque in Belgrave Square honors his work as a physician and illustrator.

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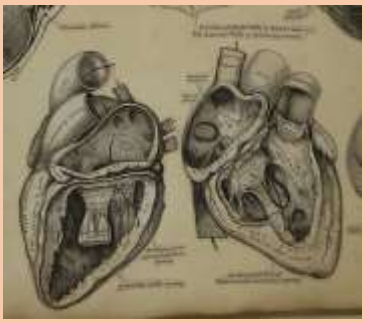

Vandyke Carter,s illustration of the heart from Gray's Anatomy

Henry Vandyke Carter, Cerebral arterial supply to the brain, 1918, from Gray's Anatomy 20th edition.

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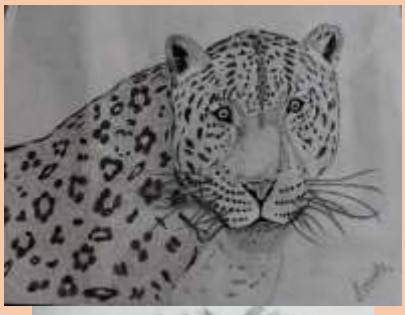
HOBBY SECTION

Sketching



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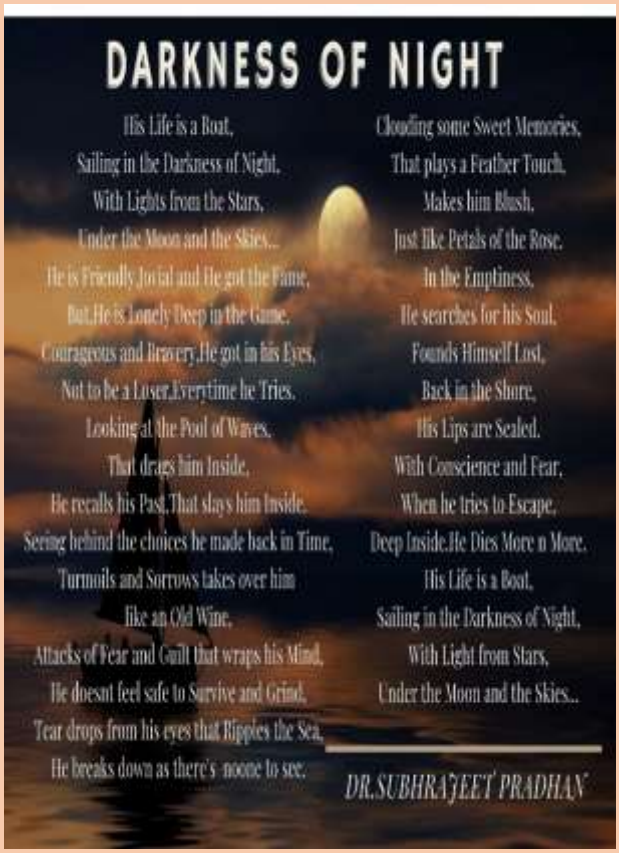
"DARKNESS OF NIGHT"



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POEM: The Plastic Surgeons" for Public awareness..

पलास टक सरनस?? कौन होतेहैयेलोग , कया ही करतेहै?
सेलेबटीज़ की सरी करतेहोगे, कही सेपलास टक लाकेलगातेहोगे
जानेकया ही करतेहोगे?

मांको अपनेबचचेका कान
खींचनेका अधधकार ददलातेहैम
(Ear defect correction)
आग सेपीडड़तो का हाथ
हर हाल मेथामेरखतेहैम
(Acute burn management)
जलेहुए उनकेजखमो को
चांदी सेसहलातेहैम
(Burn wound management)
उनको ज़ज़नदगी केसाथ
जीनेका मतलब ससखातेहैम
(Post burn deformity correction)
बस इतना ही करतेहैम

कैसर मेखोयेहुए अंग केसाथ साथ
खोयी हुई पहचान भी वापपस लातेहैम
(Oncoplastic reconstruction)
ददल, पैर, रीड की हडडी या कही का भी हो इमपलांट
उसेशरीर मेपनहु छुपातेहैम
(Reconstructive surgery)
बड़ेसेबड़ेघाव सेलेकर (trauma reconstruction)
छोटी सेछोटी चोट को भी सरी सेछुपातेहैम
इसीललए सकमु नसो की भी
इजजत करतेहैम
(Micro vascular Surgery)
बस इतना ही करतेहैम ..

बढती हुई आपकी उम को
बोटॉकस का बेक लगतेहैम
(Fillers and Botox)
अनचाहेननशानो सेआपको
छुटकारा ददलातेहैम
(Scar Revision)
ससर लोगो केचेहरेही नहीं
दननयाु को भी खबसूरतू बनातेहैम
सेलेबटीज़ केसाथ साथ आम
लोगो को भी खास बनातेहैम

बचचो की खोयी हुई पयारी मसकानु
वापपस लातेहैम
(Cleft lip surgery)
उनकेननहेननहेहाथो को
बंधन सेछुड़ातेहैम
(Congenital hand defect surgery)
उनकेछोटेसेमासमू चेहरेको
और भी पयारा बनातेहैम
(Cranio facial and vascular Malformation surgery)
उनकेपानी पपनेसेलेकर सुसुकरनेतक का
सफर तय करवातेहैम
(Cleft palate,Hypospadias surgery)
बस इतना ही करतेहैम
सननु पड़ेहुए हाथो को
फफर सेछूना ससखातेहैम
(Nerve repair)
बेजान सी उंगललयो को
अपनेहुनर सेचलातेहैम
(Brachial plexus and Tendon surgery)
कटेहुए अंगो को
बारीकी सेजोड़ देतेहैम
(Replant surgery)
सखेपड़ेशरीर केहहससो मे
फफर सेखनू पहुचातेहैम
(Vascular surgery)
ससर पनरुजनृ ही नहीं
शनयु मेसेभी सजनृ कर लातेहैम
(Total forearm reconstruction from free flap)
बस इतना ही करतेहैम

खोयेहुए आपकेआतमववशवास को आपसेवापपस ममलवातेहैम
(Aesthetic Surgery)
चेहरेऔर शरीर केसाथ साथ समाज की सोच को भी बदलतेहैम
(Gender Change Surgery)
ससर चमड़ी लगातेही नहीं(Skin grafting)
चमड़ी केकैसर को भी ननकालतेहैम (Skin Cancer Surgery)
बस इतना ही करतेहैम

सरी की जादई दननयाु को चमतकाररक "आभास" सेभर देतेहैम
इसीललए सरनस केभी सरनस कहलातेहैम
बस इतना ही करतेहैम, बस इतना ही करतेहैम बस इतना ही करतेहैम .....

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Humorous Anecdotes

In the summer holidays between two terms, two of us (both in 1st year), decided to raid the air-conditioned anatomy embalming room and claim 'fresh' bodies for dissection. Unfortunately, all the bodies were dried up and shriveled. At last, we saw a fresh one, and both of us jumped to claim it. To our utter consternation, the so called body sat up with a surprised look. It was the bare bodied technician, clad only in a knee length dhoti, disturbed in his afternoon siesta. We competed with each other in beating a hasty retreat.

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Fresh medical students were being taught to measure blood pressure in the physiology class. With one of the students, acting as the subject, the instructor raised the pressure in the cuff of the sphygmomanometer to obliterate the pulse and asked us to confirm. All agreed, except a pretty girl, who insisted that she could still feel the pulse. After checking twice, the instructor was about to lose his temper, when he whispered something into the subject's ear. He readily admitted that whenever the girl touched him, his heart started thumping, and the blood pressure shot up. No wonder the girl could feel the pulse. It was a normal physiological response of a healthy male

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We did not have a dress code in our Medical College. But everyone was expected to come in sober clothes. One boy used to flaunt his flashy dresses in the class. Some of us decided to teach him a lesson, by sprinkling picric acid on his clothes in the biochemistry practical class. The victim came to know our plan, and was keeping a very close watch on our movements, thus preventing us from surprising him. In doing so, he could not concentrate on the day's experiment, which consisted of drawing a measured amount of urine sample in a pipette, and measure the diastase level. Inadvertently, he drew the 'sample' into his mouth. His loud protests, that the sample, which he tasted, was his own, fell on deaf ears, as the rest of us supplied the sample centrally. However, the exercise served its purpose, in that, the boy stopped coming to class in flashy clothes.

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Achievement/award winning research in academic field

Dr. Nutan Jain, MS(Obs.& Gynae), Vardhman Trauma & Laparoscopy Centre Pvt. Ltd, Muzaffarnagar. "Jain Point: A Viable option in Contra-indications of Palmer's Point: A Ten years study" won the Best Innovation Paper Award 1st Prize (Session -7) in the 81st Annual Conference of ASI (The Association of Surgeons of India) virtual ASICON – 2021. It has been a step forward in making Laparoscopic entry safer and a much-needed entry port in contraindications of Palmer's point.

Dr. Naveen Kumar - Presented a new modification of Kulkarni urethroplasty, at PENRECON 2022 in Ahmedabad, an international conference on reconstructive urology (www.penrecon.in) and won third prize in the best paper session.

Dr. Manoj Saha- Doing plantation work in and around Guwahati city for last 10 years. In recognition of his work towards green earth, he was facilitated and a citation was offered by Guwahati branch of Indian Medical Association on this world environment day.

OSE SM, SHARMA SC, MAZUMDAR A, KAUSHIK R. BREAST CANCER: COMPREHENSIVE MANAGEMENT (SPRINGER NATURE, SINGAPORE. First Edition 2022)

Breast cancer is spreading like wild fire in India. Compared to patients in other countries, Indian patients have delayed presentation resulting in advanced disease, poor prognosis, different hormonal status, multiple societal and local issues that need management with an eye on local resources and hospital facilities. There has been a paucity of Indian textbooks dealing with the problems of breast cancer in India, and there is hardly any comprehensive book from India that deals with all aspects of this controversial disease. We have been relying upon foreign textbooks to let us know how to manage our patients. The recent book entitled Breast Cancer: Comprehensive Management (Springer Nature, Singapore, 2022) edited by Shashanka Mohan Bose et al attempts to do just this, and covers a myriad of topics in depth, starting from the scenario of breast cancer in India to other important topics such as anatomy, physiology, etiopathogenesis, diagnostic techniques, approach to such patients, tumour markers, with detailed management of early, locally advanced, metastatic and recurrent breast cancer. The book also covers chemotherapy, radiotherapy, hormonal and other targeted therapies available for the management of these patients as well as important yet neglected topics such as the management of chemotherapy complications, lymphedema and psychosocial aspects of breast cancer. For those interested, there is also a chapter on organisation of a breast cancer management group. All in all, the book covers all aspects of breast cancer and will be useful for post-graduates, advanced learners as well as astute professionals across medical specialties who have a special interest in breast cancer and are dealing with such patients.
All the chapters in this book are written by well-known Indian auth ors who are experts in the field of breast cancer, drawn from renowned Institutions like AIIMS New Delhi, PGIMER Chandigarh, Tata Mumbai, SGPGI, Lucknow, Safdarjang Hospital New Delhi, GMCH Chandigarh, CMC Ludhiana, and many others. It is very nicely designed and printed by Springer, one of the best publishers of medical books in the world, and it has 31 black and white and 155 colour illustrations. The book is available as hard copy as well as ebook, and can be purchased through the publisher website (link.springer.com), Amazon and other local as well as online stores. Amazon presently is offering an initial discount of almost 26%, so it is a good time to buy the book and update your knowledge of breast cancer.

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Travelogue

Spain

Spain has always been an enigma for many. The mention of 'Spain' conjures up images of the 'Tomatina' festival, the bullracing and the boisterous football-crazy fans. It had always attracted tourists from world over for fun and adventure alike. Our holiday in Spain continues to remain one of the most memorable ones.

Lufthansa Airlines brought us to the port town island of Ibiza via Frankfurt. Vueling airlines then carried us across the Mediterranean Sea to the mainland in Barcelona famous for its football, racing and tomatoes. Among all the places we visited, the countryside, particularly De-Nuria was the most memorable. It is near to the charming medieval-era village in the Ripoll, with narrow streets, quaint marketplace, stone-carved pavements and alleys. The tiny countryside village had an untouched virgin beauty to it. The people were unhurried in their early morning shopping for vegetables, fresh homegrown fruits and freshly baked bread. The De-Nuria valley was situated among the Pyrenees mountains, with a beautiful pristine lake in the center at the top. The only way to this valley was a special Railway track with the most modern coaches that took us up a serpentine 12 kms track to its final destination, the mountain top. On the lake side, we had our choice of 'cheese and the red wine' tasting that was most memorable.

The return trip was somber and full of nostalgia of the previous week filled with absolute bliss. Lufthansa brought us back from Barcelona via Munich.

Spain is a dream European destination and the Spanish are mostly friendly people. It is a melting pot of local populace and tourists alike. Although the local language is Spanish or Ctalonian, most people speak English. The Spanish just love their life, just as they love their music, their football and flamenco dance.

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Off roading in Arunachal Pradesh

India offers tremendous potential for adventure tourism. This potential is hardly tapped into. Having been a high altitude tracker for 25 years, I ventured on an off roading driving expedition recently. The north east of India has many as yet unexplored areas. We chose Arunachal Pradesh for this 14 day expedition.. Our guide was Nidhi Satty of Wander Beyond Boundaries (https://www.wanderbeyondboundaries.com/). Ours was a group of 11 members in 3 Mahindra Thars and two Toyota Fortuner vehicles. All the vehicles 4 Wheel drives. The expedition was very professionally planned and executed. The expedition started and ended at Pasighat (See Map). We travelled East and reached Miow on very nice metalled roads. From here we took over two days to reach Vijayanagar on the Burmese border. Drive through Namdapha forest was truly breathtaking with tall trees, dense vegetation and the meandering Noa-Dihing river in the valley. The road through the forest is fairly basic and after a few kilometres from Miao, the drive to Gandhigram which is close to Vijayanagar has a very rudimentary road connection. The road was being built in this area. It was quite a challenge because of the terrain with frequent rains and landslides. Generally this area is only negotiable by four wheel drive Tractors. Ours was the first convoy of cars to reach Vijayonagar. This little town is maintained by air through regular sorties by the Indian Air Force. The drive itself was exhilarating and challenging with the four-wheel-drive being engaged for most of the journey. Driving through deep slushy roads with the possibility of a skid looming large, was an adventure in itself. At times, we got down to the valley as the road had been washed away. We had to negotiate river streams to bypass this area and come back on to the road. At one point on the way back we had an exciting river crossing as well with the vehicles rolling over large boulders on the river bed. The navigation by our leader through this river bed taking the help of a local who knew the river well, was an exceptional experience. After visiting Vijoynagar we headed north to Kaho, the easternmost village of India on the Chinese border. From there we made our way back to Pasighat. The accommodation all along was basic with stays in village houses, or camping by the riverside. On some days we had the luxury of Homestays. Expeditions like this are learning experiences in life. I believe that these are essential for surgeons. They teach us things like humility, teamwork, interdependence, and take away ego and hierarchy. Expeditions demonstrate basic lessons of life, reinforcing the value of simplicity, empathy and gratefulness.

Photos courtesy WBB and Sandesh.
Interesting links:
Facebook Page of WBB - https://www.facebook.com/wbbxol
Video of expedition - Part 1 - https://www.youtube.com/watch?v=GGqy_xETQAI
Video of expedition - Part 2 -

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Visit at Spiritual Places in India

Rewari Senior Surgeons- Dr R S Yadav, Dr Ajay Aggarwal & Dr Kartar Singh Yadav EC Member Team Haryana with Families visited the spiritual place like Auli famous for Winter Sports Of Uttrakhand. This developed bonding between them.

A Spiritual Visit By Members of ASI Rewari to Badrinath and place like, Last Village of India- MANA, Ganesh Gupta, Udgam of River Saraswati, Millio of river Saraswati with Mandakani & Alaknanda rivers them making river ganga.

Dr Kartar Singh EC from Haryana Visited with family the famous temple Vishwanath with friend and participated in the famous Ganga Arti at the Bank of Holy river Ganga.

The photographs are attached below

Dr. Kartar Singh Yadav
Dr R S Yadav
Dr Ajay Aggarwal

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Mukteswar & Nainital Visits

Recently I went to Mukteswar-a hill station in Uttarakhand, stayed in zostel which was an unique experience for all bag packers. Zostel is a very affordable stay and also very comfortable.



Then I went to Nainital-this is a very beahill station with lake view. There mall road is very beautiful with the amazing hot chocolate and pastries. Nice cafes are there.



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UPCOMING ACTIVITIES

WELCOME MESSAGE

Greetings from ASI, MASI (Maharashtra State Chapter), MSS (Mumbai Surgical Society – City Chapter). After two tumultuous years, normalcy seems to be coming back to mankind and we pray to the Almighty, to keep it as such.

Yes friends, here we go... the first physical ASICON after two full years and that too at a city that never sleeps, never fails, dreamers' paradise and citizen's pride... yes you got it right... MUMBAI Meri Jaan. The 82nd Annual Conference of The Association of Surgeons of India "ASICON 2022" will be held in Mumbai from 21st to 24th December 2022. An unwinding academic feast, always sought after by the surgeons of this country awaits you to de-stress in the background of learning and teaching what we are best at... Surgery.

Having the privilege of hosting you all after a long gap of 25 years, the organising team needless to say is overexcited and enthusiastic to come up to more than your expectations. From Scientific deliberations amongst the globally renowned faculties to showcasing your own works; from sumptuous multi-cuisine menus to the most extravagant entertainment; from meeting your lowest and liked ones to exploring the most explicit sights... Mumbai is geared up for all. The magic of Mumbai has always left all spellbound and there are uncountable reasons why Mumbai enjoys the status of being the most loved city of all times. Mumbai city has been classed as an "Alpha World City". It is also the financial centre, economic powerhouse, and industrial hub of India. The city offers excellent infrastructure in terms of well-connected International, as well as, National airports, railway stations, and roads. The newest addition of Metro and excellent Hotels, of all categories, which are in the heart of the city, hence making the city an excellent choice for hosting a conference of this scale. Besides, Mumbai is a Traveller's paradise. Right from the holy sites to often crowded beaches, from colourful bazaars to happening nightlife and from skyscrapers to high-end hotels, Mumbai is filled with attractions that you cannot give a miss.

We look forward to active participation from all our members and Team ASICON 2022 Mumbai is waiting with open arms to welcome all with a rousing reception.

Organizing Team
ASICON 2022

Conference Secretariat:

Vama Events Pvt. Ltd., Kohinoor Square Phase I, B Wing, Office No. 1004, 10th Floor, N. C. Kelkar Road, Shivaji Park, Dadar West, Mumbai 400 028.

Tel.: 022-35131930, 022-35131931, 022-35131932, 022-35131933 / 022-46052832 | Email: conferences@vamaevents.com

https://www.asicon2022.com

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State Chapter Conferences

Name of Event	Dates
Annual Conference Punjab State Chapter	1 – 3 October 2022
GUJASICON 2022 Annual Conference – Gujarat State Chapter of ASI	14- 16 October 2022
UPASICON 2022- Annual Conference – UP State Chapter of ASI	28- 30 October 2022
SURGICON 2022 Annual Conference – Delhi State Chapter of ASI	11- 13 November 2022
OSASICON 2022 - Annual Conference – Odisha State Chapter of ASI	18 – 20 November 2022

Sectional Conferences

Name of Event	Dates
IAESCON 2022- Annual Conference – IAES	15- 17 September 2022
ACRSICON 2022 Annual Conference – ACRSI	22-24 September 2022
AMASICON 2022- Annual Conference – AMASI	18-20 November 2022

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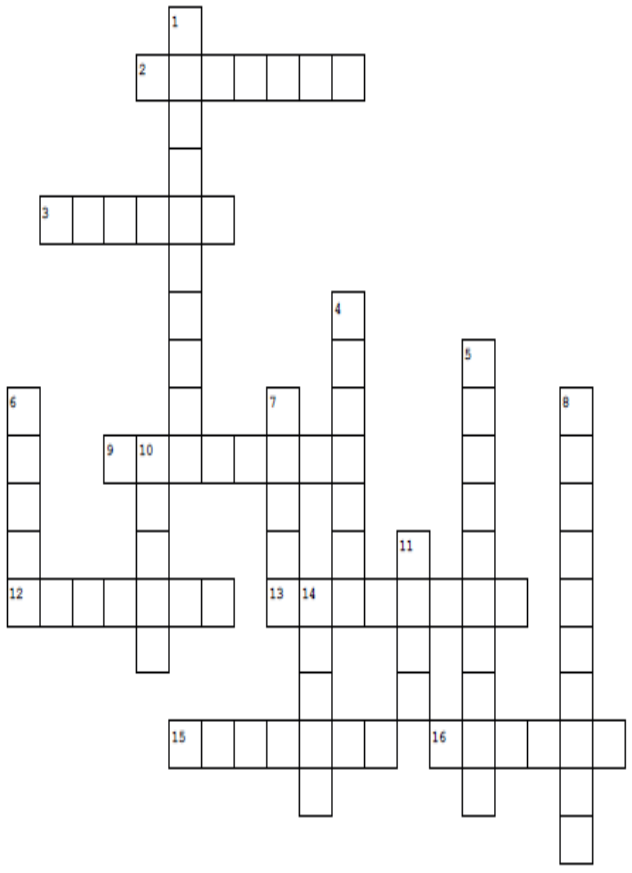
CROSSWORD

Open surgical instruments



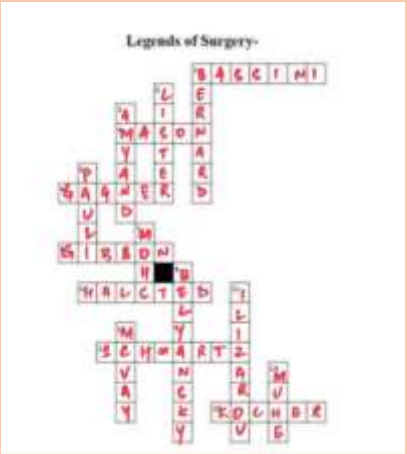
Across

2. Forceps used for atraumatic tissue grasping
3. Retractor used to retract the abdominal wall
9. sponge holding fprceps
12. and some intra-abdominal suction
13. Suction Tube used primarily for surface
15. clamps with slightly rounded jaws used for grasping intestine.
16. Traumatic toothed clamp

Down

1. Metzenbaum Scissors: Lightscissors used for cutting delicate tissues
4. Forceps used for atraumatic tissue grasping during dissection
5. forceps having blunt ended teeth used to grasp tough tissues
6. Fine scissors used for creating incisions in blood vessels and ureter
7. Larger size hemostat for grasping larger tissues
8. hook shaped retractor with an L-shaped end
10. clamps with toothed jaws used for grasping tough tissues
11. tissue tissue forceps have interlocking teeth
14. Forceps toothed at the tip used for handling dense tissue

Solved Crossword (Previous Edition)



Winners

Dr Alish Mehta

MBBS, DNB (General Surgery),
Ramkrishna Care Hospital, Raipur

Dr. Vivek Rajdev

MO Specialist
Dr. RKGMC, Hamirpur, H.P

Dr Shalin Shah

Senior Resident
SVP Hospital, Ahmedabad

Dr Julie Shah

Rules: The solved Crossword puzzle on a printout (as a pic) should be sent as an attachment to asi.scalpel@gmail.com from your registered email ID. The puzzle is open to all members of ASI. The first 3 correct email entries received will have the winners name mentioned in the next edition of SCALPEL.

Compiled by : Dr. Ashish Dey, Senior Consultant, Sir Ganga Ram Hospital & Editorial Secretary, Delhi Chapter-ASI

SCALPEL

Newsletter of Association of Surgeons of India

From the Desk of Editors

Dr. Tarun Mittal

Dr. Rajesh Prajapati

Dr. Madhumita Mukhopadhyay

Respected Seniors, Dear Colleagues & Students,

It an honour to contribute as Editors of "SCALPEL" and present the achievements and the activities Association of Surgeons of India. Newsletter is a medium through which we can express ourselves. We hope we have been able to live up to expectations of our members and seek apology for any shortcomings. It was heartening to receive so many articles for the second edition of "SCALPEL" from younger surgeons.

We request all of you to actively participate in the Annual Conference of ASI i.e. ASICON 2022 in Mumbai and make the event a grand success.

We wish all the members a happy, safe and prosperous Diwali.

Looking forward for your support and guidance.

Long Live ASI !!