ENDOSCOPIC SURGICAL SOCIETY (MYANMAR)

MYANMAR
Endoscopic Surgical Society

3rd International Conference

Program Book

"SHARING EXPERIENCE AND BETTERING ENDOSCOPIC SURGERY"

October 7 – 8, 2017

Novotel Hotel Max

YANGON

WELCOME MESSAGE FROM THE PRESIDENT

The upcoming 3rd International Endoscopic Surgical Society Conference will take place in the beautiful city of Yangon on 7th and 8th of October 2017, with the Pre-conference Workshops of various specialties at their respective University Teaching Hospitals on 6th. The theme of the conference this year is "Sharing Experience and bettering Endoscopic Surgery".

Our Endoscopic Surgical Society is remarkable for its components of many surgical specialties like general surgery, neurosurgery, orthopaedic surgery, thoracic surgery, cardiac surgery, hepatobiliary & pancreatic surgery, ORL-HNS, urology, Gynecology etc. As a result, you can experience diverse presentations from various specialties, a rare opportunity to have at a single conference.

In addition to 6 preconference live surgery workshops, there will be symposiums, free paper presentations, video presentations and Nurse Symposium.

Learning from each other and sharing experience is the prerequisite of advancement and thus we have created a friendly and pleasant environment to fulfill this aim for everyone. We can ensure that you will return home with a bunch of new experience and a memory of wonderful stay in Myanmar.

We certainly hope to have you on board and look forward to welcoming in Yangon.

Kind regards,

Professor Toe Lwin
President,
Endoscopic Surgical Society, Myanmar

COMMITTEES

Organizing Committee

Chair: Prof. Toe Lwin

Secretary: Prof. Tin Tin Mar, AP Tun Nyunt,
Dr. Sai Lao Ngin, Dr. May Thwe Thwe Win

Academic Committee

Chair: Prof. Aye Mon

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Chair: Prof. Myo Myat Thu

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Reception Committee

Chair: Prof. Thein Lwin

Secretary: AP. Daw Win Yee, Dr. Khin San Khine

PRECONFERENCE WORKSHOPS

Friday, 6th October, 2017

Speciality	Venue
Urosurgery	Yangon Speciality Hospital
Thoracic Surgery	Yangon Speciality Hospital
Paediatric Surgery	Yangon Children Hospital
Otorhinolaryngology—Head and Neck Surgery	Otorhinolaryngology—Head and Neck Surgery Specialist Hospital, Yangon
Obstetrics and Gynaecology	North Okkalarpa General Hospital
General Surgery	New Yangon General Hospital Yangon General Hospital
Cardiovascular Surgery	Yangon General Hospital

PROGRAM OVERVIEW – Day 1, Saturday, 7th October, 2017

Pyay Hall

Time	Symposium
8:00 – 8:30	Opening Ceremony
8:30 – 9:00	Coffee Break, Photo Session
9:00 – 10:00	Thoracic Surgery I
10:00 – 11:00	Urology I
11:00 – 11:30	Otorhinolaryngology—Head and Neck Surgery
11:30 – 12:30	O & G
12:30 – 13:00	Lunch
13:00 – 14:00	Paediatric Surgery
14:00 – 15:00	General Surgery I
15:00 – 15:15	Coffee Break
15:15 – 16:15	HBPS
16:15 – 17:15	Free Paper Session I
19:00 – 22:00	Gala Dinner at Novotel Hotel Max

Satellite Symposium, Saturday, 7th October, 2017

Napyitaw Hall

Time	Topics
9:00 – 10:30	Educational Meeting for ASEAN Federation Moderators: Professor Htun Oo / Professor Thein Lwin
14:00 – 15:00	Nurse Session Moderators: A.Prof. Tun Nyunt, Dr. Sai Lao Ngin Speakers: Dr. Yee Chan A.Prof. Tan Yung Khan

PROGRAM OVERVIEW – Day 2, Sunday, 8th October, 2017

Pyay Hall

Time	Symposium
8:00 – 9:00	Thoracic Surgery II
9:00 – 9:15	Coffee Break
9:15 – 10:15	General Surgery II
10:15 – 11:15	Neurosurgery
11:15 – 12:15	Cardiovascular Surgery
12:15 – 1 2:45	Lunch
12:45 – 13:45	Urology II
13:45 – 14:45	General Surgery III
14:45 – 15:00	Coffee Break
15:00 – 16:00	Free Paper Session II
16:00 – 16:30	Closing Ceremony ○ Closing Remark by Prof. Toe Lwin, President of ESS (Myanmar) ○ Presenting Appreciation Tokens to the Faculties

Anette Sundfor Jacobsen, MB, BCh, BAO, LRCP & SI, FRCSEd, MMed (Surgery), FAMS,
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Urological Surgeon, Western General Hospital, Edinburgh

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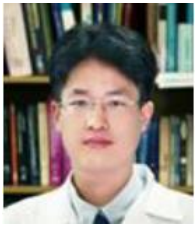
Professor and Chairman Department of Cardiovascular Surgery, Tokyo Women's Medical University, Tokyo, Japan



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Adjunct Assistant Professor, YLL School of Medicine, NUS, Adjunct Assistant Professor, DUKE-NUS Graduate Medical School Clinical Teacher, LKC School of Medicine, NTU Head, Ambulatory Services Honorary Secretary, College of O & G, Singapore

Kyung-Suk Suh
Professor and Chairman, Department of Surgery, Seoul National University College of Medicine, Seoul National University Hospital, South Korea

Kwang-Woong Lee, M.D., Ph.D.
Professor
Department of Surgery, Seoul National University Hospital, South Korea

Mohd Zulkiflee Abu Bakar
Associate Professor in Faculty of Medicine, University of Malaya and Consultant Otorhinolaryngologist, Head & Neck Surgeon in University of Malaya Medical Centre, Kuala Lumpur

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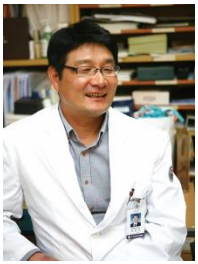

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Tan Yung Khan
Associate Professor, Lee Kong Chian School of Medicine (Singapore) Senior Lecturer Yong Loo Lin School of Medicine (Singapore)
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Associate Professor,
Cardiovascular Surgery Saitama Medical University International Medical Center

V. Venkatesh
Director, V.G. Hospital, Indian Institute of Laparoscopic Surgery Research and Training

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Yee Chan, FRACS
Consultant Urologist, Austin Health and Maroondah Hospital, Melbourne, Australia

LOCAL SPEAKERS

Aung Kyaw Tun, M.B.,B.S, M.Med.Sc (Surgery), MRCSEd, Dr.Med.Sc (Urology), Consultant Urologist, Department of Urology, No.2 Defense Service General Hospital (1000 bedded), Napyitaw

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No (2) Defence Services General Hospital, Nay Pyi Taw, Myanmar

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Khin Aung Tun, M.B.,B.S, M.Med.Sc (Surg), FRCS, FICS, Dr.Med.Sc (General Surgery), Professor and Head of Department of Surgery, Defense Service Medical Academy

Kyaw Htet, M.B.,B.S, MMedSc(Surgery), MRCSEd, Member of JGES (Japan), Fellowship in GI and HBP Surgery (NMS, Tokyo)

Maung Maung Swe, M.B.,B.S, M.Med.Sc (Anaesthesiology)
Associate Professor, Department of Anaesthesiology, Yangon Speciality Hospital

Min Thu, M.B.,B.S, M.Med.Sc (Surgery), FRCS, Dr.Med.Sc (Urology)
Professor and Head, Department of Urology, University of Medicine, Mandalay

Moe Myint, M.B.,B.S, M.Med.Sc (Surgery), FRCS (Glasgow), FRCSEd
Professor and Head, Department of Surgery, University of Medicine Magway

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Tin Soe, M.B.,B.S, MSc (Surgery), FRCS, Dr Med Sc (Chest), Dip: ME
Professor & Head of Department of Thoracic Surgery, Mandalay General Hospital

Tin Maung Lin, M.B.,B.S, M.Med.Sc (Surg), MRCSEd, Dr.Med.Sc (Urology)
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Thuya Aung, M.B.,B.S, M.Med.Sc (Surgery), MRCSEd
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PROGRAM DETAILS
Day 1 – Saturday, 7th October, 2017

9:00 – 10:00 Thoracic Surgery I

Chair Persons: Prof. Maung Maung Khin, Prof. Mu Mu Naing

9:00 – 9:15 History of VATS in Myanmar
A.Prof. Hlwan Moe Htet (Myanmar)

9:15 – 9:30 Anaesthetist's Consideration in Conventional VATS
A.Prof. Maung Maung Swe (Myanmar)

9:30 – 9:45 Non-Intubated Video-Assisted Thoracoscopic Surgery
Prof. Sook Whan Sung (Korea)

9:45 – 10:00 Anaesthetist's Consideration for Non-Intubated Video-Assisted Thoracoscopic Surgery
A.Prof. Joonpyo Jeon (Korea)

10:00 – 11:00 Urology Session I

Chair Persons: Prof. Toe Lwin, Prof. Kyaw Swar Hlaing

10:00 – 10:15 Laparoscopic Reconstructive Urology: Radical Cystectomy and Intracorporeal Urinary Diversions
Dr. Allen Sim Soon Phaung (Singapore)

10:15 – 10:30 Laparoscopic Donor Nephrectomy: Techniques and Maximizing the Length of Vessels
Dr. Yee Chan (Australia)

10:30 – 10:45 Role of Robots In Gaining Access In PCNL
A.Prof. Tan Yung Khan (Singapore)

10:45 – 11:00 Overcoming Adverse Events in Laparoscopic Urology
Prof. Christian Schwentner (Germany)

11:00 – 11:30 Otorhinolaryngology, Head and Neck Surgery

Chair Persons: Prof. Mg Mg Khine, Prof. Soe Tin

Endoscopic Medial Maxillectomy
A.Prof. Mohd Zulkiflee Abu Bakar (Malaysia)

11:30 – 12:30 Obstetrics & Gynaecology

Chair Persons: Prof. Kyi Kyi Nyunt, Prof. Saw Kler Ku

11:30 – 11:50 Hysteroscopy Surgery: An Exciting Frontier Ahead
Dr. Khoo Chong Kiat (Singapore)

11:50 – 12:10 NOTES-assisted Vaginal Hysterectomy
Dr. Ohnmar Win (Myanmar)

12:10 – 12:30 Tips and Tricks for Using Energy Devices
Dr. Wai Phyo Maung (Myanmar)

13:00 – 14:00 Paediatric Surgery

Chair Persons: Prof. Maung Maung, Prof. Aye Aye

13:00 – 13:20 Minimal Access Approach to Hepatobiliary and Pancreatic Lesions
A.Prof. Anette Sundfor Jacobsen (Singapore)

13:20 – 13:40 Cardiopulmonary Effects of Endoscopic Surgery in Neonates
Prof. Hiroomi Okuyama (Japan)

13:40 – 14:00 The Future of Safe Surgical Practice and Training – Surgical Simulation
Mr. Ram Nataraja (Australia)

14:00 – 15:00 General Surgery I

Chair Persons: Prof. Win Myint, Prof. Thein Lwin

14:00 – 14:20 Management of Complex Abdominal Wall Herniae
Prof. Davide Lomanto (Singapore)

14:20 – 14:40 ?
Dr. Suthep Udomsawaengsup (Thailand)

14:40 – 15:00 TAPP In Strangulated Obturator Hernia
Dr. Aung Lwin (Singapore)

15:15 – 16:15 Hepatobiliary and Pancreatic Surgery

Chair Persons: Prof. Han Win, Prof. Tin Tin Mar

15:15 – 15:35 How I do a Laparoscopic Donor Hepatectomy
Prof. Kyung-Suk Suh (Korea)

15:35 – 15:55 Principle of Laparoscopic Liver Resection and Tips and Tricks
Dr. Wipusit Taesombat (Thailand)

15:55 – 16:15 Tips and Tricks of Surgical Staplers
Dr. Kwang Woong Lee (Korea)

16:15 – 17:15 Free Paper Session I

Chair Person: Prof. Htun Oo, Prof. Tin Latt

16:15 – 16:30 Laparoscopic Interval Appendicectomy Using Basic Laparoscopic Instruments
Prof. Moe Myint (Myanmar)

16:30 – 16:45 Initial Experience of Laparoscopic Liver Resection in Myanmar
Dr. Ei Ei Khine (Myanmar)

16:45 – 17:00 Hybrid Endo-laparoscopic Transgastric Resection of Gastric GIST (Video Presentation)
Dr. Aung Lwin (Singapore)

17:00 – 17:15 Difficult Cholecystectomy (Video Presentation)
Prof. Moe Myint (Myanmar)

PROGRAM DETAILS

Day 2 – Sunday, 8th October, 2017

8:00 – 9:00 Thoracic Surgery II

Chair Persons: Prof. Khin Maung Aye, Prof. Tint Zaw Oo

8:00 – 8:20 Open Oesophagectomy
Prof. Tin Soe (Myanmar)

8:20 – 8:40 VATS in Achalasia Cardia
A.Prof. Hlwan Moe Htet (Myanmar)

8:40 – 9:00 Minimally Invasive Esophagectomy
Dr. Aung Myint Oo (Singapore)

9:15 – 10:15 General Surgery II

Chair Persons: Prof. Than Than Yee, Prof. Kin Fah Chin

9:15 – 9:30 Update in Laparoscopic Bariatric Surgery
Prof. Kin Fah Chin (Singapore)

9:30 – 9:45 Role of Diagnostic Laparoscopy in Management of Primary Peritoneal Carcinoma
Prof. Khin Aung Tun (Myanmar)

9:45 – 10:00 Laparoscopic Management of Paraduodenal Hernia – Case report
Maj. Hla Myo (Myanmar)

10:00 – 10:15 Enhanced Recovery Program in Laparoscopic Colorectal Surgery
Col. Kyaw Htet (Myanmar)

10:15 – 11:15 Neurosurgery

Chair Persons: Prof. Myat Thu, Prof. Win Myaing

10:15 – 10:35 Practical usage of EndoArm for Various Intracranial Diseases
Prof. Shigeki Ono (Japan)

10:35 – 10:55 Our Treatment Results of Intraventricular and Paraventricular Tumor: Comparison Between Adult Cases and Pediatric Cases
A.Prof. Kameda Masahiro (Japan)

10:55 – 11:15 Neuroendoscopy in Yangon General Hospital
Dr. Sein Win (Myanmar)

11:15 – 12:15 Cardiovascular Surgery

Chair Persons: Prof. Khin Maung Aye, Prof. Khin Maung Lwin

11:15 – 11:35 Current Situation of AS Treatment and Role of Heart Team: Situation in Japan
Prof. Hiroshi Niinami (Japan)

11:35 – 11:55 New Strategy for Aortic Dissection with Endovascular Stent-graft Technologies
Prof. Toshihisa Asakura (Japan)

11:55 – 12:15 Endoscopic Long Saphenous Vein Harvesting for CABG Surgery: A Single Center Experience-NUH, Singapore
Dr. Darren Lee (Singapore)

12:45 – 13:45 Urology Session II

Chair Persons: Prof. Than Aye, Prof. Khin Tun

12:45 – 13:00 Laparoscopic Surgery in Urology at Naypyitaw General Hospital
Prof. Shwe Win (Myanmar)

13:00 – 13:15 Principles of Flexible Endoscopy for Surgeons
Mr. David Tolley (UK)

13:15 – 13:30 Milestones of Laparoscopic Urology in Mandalay
Prof. Tin Maung Lin (Myanmar)

13:30 – 13:45 PCNL: Mandalay's Perspective
Prof. Min Thu (Myanmar)

13:45 – 14:45 General Surgery III

Chair Persons: Prof. Shein Myint, Prof. Thein Myint

13:45 – 14:05 Update in Laparoscopic Gastric Cancer Surgery
Prof. Park Young-kyu (Korea)

14:05 – 14:25 Our Surgical Procedure of Laparoscopic Gastrectomy for Gastric Cancer
Dr. Taiki Moriyama (Japan)

14:25 – 14:45 3D vs 2D Laparoscopy
Dr. Venkatesh (India)

15:00 – 16:00 Free Paper Session II

Chair Persons: Prof. Kyi Soe, Prof. Phone Myint

15:00 – 15:15 Laparoscopic Ventral Hernia Repair: The initial 5 years' Experience
Dr. Thuya Aung (Myanmar)

15:15 – 15:30 Endourology in Military: Where are we?
Dr. Aung Kyaw Tun (Myanmar)

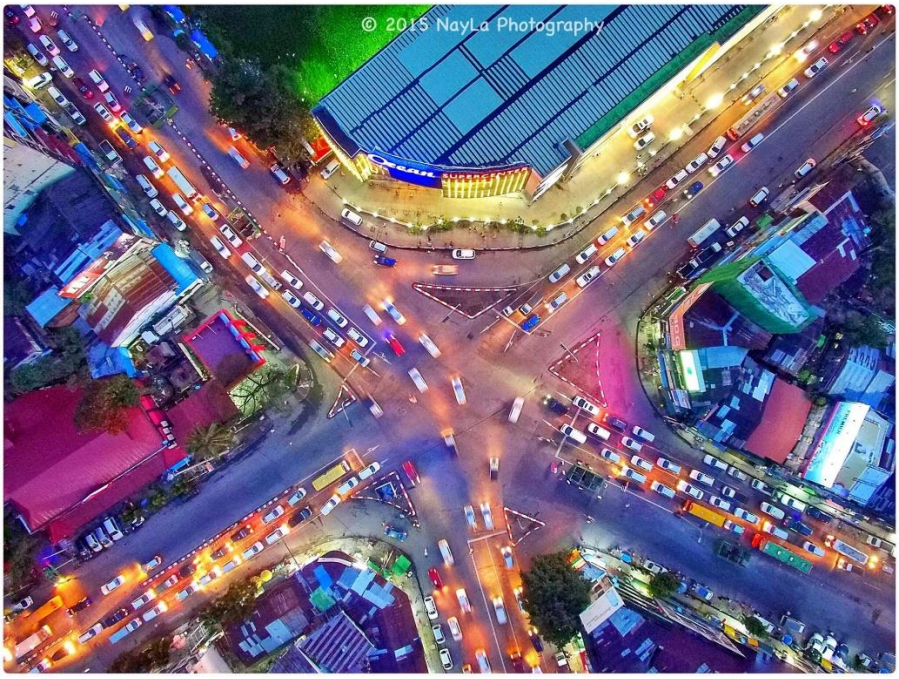
15:30 – 15:45 Laparoscopic Surgery in Urology: Personal Experience
Dr. Win Min Htet (Myanmar)

15:45 – 16:00 Percutaneous Biportal Endoscopic Spine Surgery for Lumbar Diseases: A Technical Note and Preliminary Clinical Results
Dr. Thant Zin Naing (Myanmar)

16:00 – 16:30 Closing Ceremony

- Closing Remark by Prof. Toe Lwin, President of Endoscopic Surgical Society (Myanmar)
- Presenting Appreciation Tokens to the Faculties

Abstracts



Non-intubated Video Assisted Thoracoscopic Surgery

Sook Whan Sung, Youngkyu Moon, Yunho Kim,
Department of Thoracic & Cardiovascular Surgery, Seoul St. Mary's Hospital, College of Medicine, The Catholic University of Korea, Seoul, Republic of Korea

Non-intubated video assisted thoracoscopic surgery (VATS) is one of the emerging issues in minimally invasive thoracic surgery. Conventionally, it is performed under tracheal intubation with double lumen tube or bronchial blocker to achieve one-lung ventilation. Although tracheal intubation with one-lung ventilation is widely accepted as a standard of care in thoracic surgery, intubation-related potential complications are not negligible.

Recently, Non-intubated VATS is therefore evaluated in the last decade, and VATS without tracheal intubation were demonstrated to be feasible and safe in a series of VATS procedures for management of a variety of thoracic disease. We have been conducting non-intubated VATS since 30th August 2016.

Anesthetic Considerations for Non-Intubated Video-Assisted Thoracoscopic Surgery

Joonpyo Jeon, Wonjung Hwang
Department of anesthesiology and pain medicine, Seoul St. Mary's Hospital, College of Medicine, The Catholic University of Korea

Since the development of mechanical ventilation in the 1960s, general anesthesia with intubation and one-lung ventilation has always been considered essential for thoracic surgery. In the recent decade, non-intubated video-assisted thoracoscopic surgery (NIVATS) has been increasingly employed in a variety of procedures involving pleura, lungs, and mediastinum. The concept is to allow the creation of a "surgical pneumothorax" as the surgeon opens the chest. This can provide excellent lung isolation without the need for positive pressure ventilation on the dependent lung. However, potential hazards include paradoxical respiration and mediastinum shift after surgical pneumothorax, which may cause progressive hypoxia, hypercapnia and hypotension. Anesthesiologists should be knowledgeable on the physiological changes and be aware of the potential problems. With appropriate monitoring, meticulous employment of sedation, and proper loco-regional anesthesia, NIVATS is proved to be a safe alternative to the conventional intubated general anesthesia.

Laparscopic Donor Nephrectomy: Maximising The Lengths of Vessels

MR YEE CHAN
Department of Urology, Austin Health, Melbourne, Australia

Introduction: Maximising the lengths of vessels is one of the most important objective in donor nephrectomy. Achieving such an objective can be technically challenging during laparoscopic donor nephrectomy. This is particularly the case when the right kidney with a shorter renal vein has to be used as the donor kidney. The technique of maximizing the lengths of vessels in both left and right laparoscopic donor nephrectomy is described.

Technique: Using standard transperitoneal approach to laparoscopic donor nephrectomy, the kidney is exposed after reflection of the colon. On the left, the renal vein is dissected proximal to both the adrenal and gonadal veins. For the left renal artery, its origin at the aorta is exposed after the dissection of paraaortic tissue from the aorta. Before division of the vessels, the left renal vein is secured by 2 hemolocs and the left renal artery with endo TA staples and reinforced by a hemoloc.

For a right laparoscopic donor nephrectomy, the right renal artery is dissected posterior to the inferior vena cava. The vena cava is rolled back to expose as much of the length of the artery as possible. Previously, 2 hemolocs were used to secure the right renal vein but with the new technique, a significant length of the vena cava is also exposed. This to allow the application of a laparoscopic bulldog across the side wall of the vena cava before division of the renal vein with a small cuff of vena cava. The cavotomy is then oversewn after the removal of the kidney. Such a technique allows a longer length of the right renal vein to be harvested. The artery is dealt with the same way as it is in a left sided laparoscopic donor nephrectomy.

Results: 160 laparoscopic donor nephrectomies had been performed at the Austin Health since 2007. 26 were right nephrectomies. Mean warm ischaemia time was 3 minutes and 10 seconds and mean duration of operation was 3 hours. 4 cases of the right nephrectomies were performed using the technique of clamping and oversewing the vena cava. This added 20 minutes of to the mean operative times. 2 cases of post-operative bleed requiring return to theatre were encountered but they did not bleed from the main vessels. 3 cases of chyle leak were also encountered in the entire series.

Summary: Maximizing the lengths of vessels in laparoscopic nephrectomy is important in facilitating the success of a renal transplant. This can be achieved safely using the technique described above.

Role of Targeted Biopsies of The Prostate

Yung Khan

Standard systematic biopsies of the prostate have the drawback of easily missing clinically significant prostate cancers.

Recently multiparametric MRI has been shown to have high sensitivity at detecting clinically significant cancers of the prostate.

The combination of excellent imaging and specialized systems allow for fusion of MRI to transrectal ultrasound scans for accurate targeted biopsies of the prostate.

Role of nursing in Endourology

Yung Khan

The speciality of endourology has seen great changes in the last few decades with the widespread use of minimally invasive methods of surgery. The equipment in use has grown smaller and consequently are at higher risk of breakage during surgery and cleaning.

The techniques are also evolving and as the doctors continue to push the boundaries of advanced surgery it is important for nursing to keep up with these latest techniques.

Endoscopic Medial Maxillectomy

Dr. Mohd Zulkiflee Abu Bakar

Associate Professor in Faculty of Medicine, University of Malaya and Consultant Otorhinolaryngologist, Head & Neck Surgeon in University of Malaya Medical Centre, Kuala Lumpur

Over the years, neoplastic lesions over the lateral nasal wall and maxillary sinus classically have been advocated to be treated via open approach. However, in great advancements of audiovisual and endoscopic techniques, these lesions are now excised endoscopically by using delicate instruments.

Hysteroscopy Surgery: An Exciting Frontier Ahead

Khoo Chong Kiat

Hysteroscopic surgery has undergone innovative developments in leaps and bounds over the last 2 decades. Not just the fact that the instruments are now thinner and easier to use, the visual acuity of the images have been further enhanced by high definition cameras.

Acceptance of its outpatient use with minimal anaesthesia required has allowed for ambulatory hysteroscopy to become one of the most performed procedure in the O&G clinics. The invention of a handheld hysteroscope (EndoSee) without the need for a lighting tower/energy source has made the hysteroscope, for the first time, to be fully portable, literally allowing the gynaecologist to carry it along everywhere, eg in the car, from clinic to clinic etc. Although the majority of the hysteroscopies performed are for diagnostic purposes, the ever-increasing ability of a therapeutic surgery being done at the same setting are now truly gaining attention.

Hysteroscopic morcellators are the latest to revolutionise the therapeutic hysteroscopy scene. Karl Storz's Bigatti shaver, TRUCLEARTM (Smith & Nephew) and MyoSure® (Hologic) are able to remove polyps and submucous fibroids with ease, using mechanical shaving actions, instead of bipolar wire electrotrodes, thereby increasing the safety of the procedure and at the same time, the automated suction and clearance of the myoma chips has allowed for clear visualization of the cavity as the procedure progresses.

All said, the hysteroscope will soon see a resurgence of its use and acceptance as the diameter of the scope gets smaller, and the equipment costs lowered as more industrial partners come up with more innovative choices.

NOTES (Natural Orifice Transluminal Endoscopic Surgery) Assisted Vaginal Hysterectmoy

Ohnmar Win
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Natural orifice transluminal endoscopic surgery (NOTES) is a newly developed method of minimally invasive surgery in gynaecology which uses the vagina, as the surgical channel of endoscopy. Because of increased experiences from single-port laparoscopy and progress in laparoscopic instrumentation and, the surgical channel at the vagina can be established to evolve the previous concept of culdoscopy into transvaginal NOTES to broaden clinical application from diagnostic purposes or simple surgery to complex procedures.

Using transvaginal NOTES, not only adnexal surgery and hysterectomy, but also myomectomy and oncologic surgery could be performed safely and effectively in selected patients. NOTES assisted vaginal hysterectomy without cervical descent can be performed safely to avoid incision scars on the abdominal wall, prevent complications of trocar wound, and achieve better cosmetic outcomes. The indications and preoperative preparations are the same as convention total laparoscopic hysterectomy (TLH). However, there are some contraindications such as deep endometriosis, suspected adnexal lesions for malignancy, previous pelvic surgery and history of pelvic inflammatory disease that can prevents access to the pelvic cavity through the posterior fornix of the vagina and be prone to get iatrogenic injuries of adjacent organs during the access to the pelvic cavity. The technical difficulties are well demonstrated for the transvaginal NOTES such as poor visibility, difficulties in maintenance of spatial orientation, maneuverability and grasping, lack of triangulation (in parallel into the peritoneal cavity) which restricts the movements of the surgeon and limitation of the surgical field of view.

Su et al., (2012) reported the first case series of transvaginal NOTES for performing hysterectomy in 2012. Sixteen patients with benign uterine diseases underwent hysterectomy using transvaginal NOTES and they concluded that hysterectomy for the treatment of benign diseases can be feasibly carried out via trasvaginal NOTES.

In conclusion, NOTES using the vagina as an entry point to the peritoneal cavity is very promising. With the development of new instruments endoscope to

overcome difficulties, the surgical approach has the potential to have broad clinical application.

Tips and Tricks for Using Energy Devices

Dr. Wai Phyo Maung

"Heat cures when everything fails" …Hipocrates. Albucasis (980BC) used hot iron to stop bleeding. But modern electrosurgery uses high frequency electrical current. The grounding pad should be placed in well vascularized muscle mass and should have continuity monitor.

Variable that be controlled by surgeon include Power setting, Duration of action, Type of Electrode, Electrical waveform, Contact vs Non-contact, Tissue tension. The cut mode generates a continuous, low voltage current concentrating the energy over a small area. The coagulation mode generates an interrupted, high voltage current dispersed over a large surface area. Vaporization (cut mode) Fulguration (coagulation mode) are non-contact methods. Desiccation/coagulation is a direct contact method.

Bipolar technique is precise & safe. It causes less disturbance to other electronic equipment connected to the patient. Newer bipolar devices measure tissue impedance, the generator gives the alarm & stop once the tissue is desiccated. If this function is not available, you can stop application when there is reduction of water vapour or bubble.

Advanced bipolar devices or vessel sealer include Erbe Biclamp, Covidien Ligasure, Ethicon enseal, Gyrus pk. FDA burst-pressure requirement for vessel sealing is at least 360 mmHg. Most of vessel sealer can sealed upto 7mm vessels. Tissue tension should be minimal while using vessel sealing.

Ultrasonic devices are useful for dissection. The blade vibrates frequency of 55,500 Hz. It has Minimal thermal tissue damage, greater precision, less tissue charring and desiccation, minimal smoke for improved visibility, fewer instrument changes. It can seal the vessel upto 5mm (7mm). Cutting and coagulation depends on Power setting, Tissue tension, Grip pressure. Thunderbeat is combination of Ultrasonic and vessel sealer.

Minimal Access Approach to Hepatobiliary and Pancreatic Lesions

A S Jacobsen
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In Pediatric Surgery the Laparoscopic Cholecystectomy is a rare operation. Rather, the pediatric Surgeons train in Lap surgery doing Appendectomies and diagnostic internal view of pelvic organs.

Hepatobiliary and pancreatic surgery in children performed via a Minimally invasive approach is reserved for experienced MAS surgeons. It is important to measure outcomes, and know when to convert to open surgery. Neonatal \ Infant MAS approach is reserved for the very experienced MAS surgeons, when very experienced anaesthetic support is available only.

There was initially much enthusiasm for a MAS approach to Biliary atresia. There were many initial posters and free papers, but gradually it appeared the results of the Kasai Portoenterostomy was inferior applying this approach. Thus, mainly one Japanese Centre is persuing this on an experimental basis.

For choledochal cysts, the Laparoscopic or even Robotic approach has been proven to give improved results. Large series from Vietnam and China have demonstrated excellent outcomes. Current controversy centers around biliary drainage via a Hepaticojejunostomy, or the simpler reconstruction of a Hepaticoduodenostomy.

In congenital Hyperinsulinemia, a Pancreatectomy may be indicated. In focal lesions a Laparoscopic approach can give excellent outcomes.
In all of the above it is evident that outcome measures and long-term monitoring after surgery is required to ensure the best approach and the best outcomes in children.

Cardiopulmonary Effects of Endoscopic Surgery in Neonates

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Background: Endoscopic surgery for neonates are expected to provide a magnified field of vision and improve long-term outcomes with minimum invasive procedure. However, little is known about the cardiopulmonary effects of endoscopic surgery in neonates.

Objective: The aim of this study is to evaluate the respiratory and hemodynamic effects of CO2 insufflation during thoracoscopic and laparoscopic surgery in neonates.

Patients and Methods: 18 neonates (11 esophageal atresia (EA), 7 duodenal atresia (DA)) were included in this study. The CO2 insufflation pressure was 8 mmHg for the laparoscopic procedure, and 4-6 mmHg for the thoracoscopic procedure. During the operation, rectal temperature (RT), arterial pressure (AP), end-tidal carbon dioxide (ETCO2) and SpO2 were continuously recorded.

Results: 11 neonates underwent thoracoscopic repair (TR) of EA. The median age and birth weight were 1 day (1-3 days) and 2.8 kg (2.5-3.7 kg). TR of EA was completed in all cases without any complications. 7 neonates underwent laparoscopic repair (LR) of DA. The median age and birth weight were 6 days (3-15 days) and 2.7 kg (2.5-3.7 kg). LR of DA was completed in all cases without any complications. The first two patients had major anastomotic leakage which required re-anastomosis. <RT > RT was well maintained between 36 and 38 ℃ in all cases throughout the operation. <AP> In the thoracoscopic cases, AP decreased significantly during CO2 insufflation, and returned to normal range at the post insufflation period. In the laparoscopic cases, AP did not change during CO2 insufflation, and increased significantly at the post insufflation period. <EtCO2> In both thoracoscopic and laparoscopic cases, ETCO2 increased significantly during CO2 insufflation, and returned to normal range at the post insufflation period. The level of ETCO2 during insufflation was higher in the thoracoscopic cases compared to the laparoscopic cases. <SpO2> In the thoracoscopic cases, Sp02 decreased significantly during CO2 insufflation, and returned to normal range at the post insufflation period. In contrast, in the laparoscopic cases, SpO2 did not change throughout the operation.

The Future of Safe Surgical Practice & Training – Surgical Simulation.

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Consultant Paediatric Surgeon & Director of Surgical Simulation, Monash Children's Hospital, Melbourne, Australia.

Overview:
Surgical training is radically changing in many countries worldwide. The traditional Halstedian model of time-bound apprenticeship is being replaced with competency based learning surgical programmes. There has also been an increase in the use of simulation-based medical education, and with these educational principles influencing the way that we acquire and maintain new surgical skills. Therefore, the surgeons of the future will be able to acquire vital skills in a safe environment prior to actual patient contact.

These surgical simulation techniques can be incorporated into routine surgical practice using low cost, easily reproducible simulation technology. This may include the acquisition of laparoscopic skills, basic surgical skills, emergency resuscitation skills or the non-technical skills such as communication, leadership and team working. These technologies and techniques are no longer limited to specialized simulation centers as they may be performed in any environment.
Operations that are amenable to laparoscopic simulation include; laparoscopic appendicectomy, inguinal hernia repair and congenital diaphragmatic hernia repair. The models that are used have been validated, and the validation study for the LIDD (Laparoscopic Inguinal & Diaphragmatic Defect) model will be discussed. There are also multiple laparoscopic tasks that enable the acquisition of core laparoscopic skills such as; hand-eye co-ordination, 2D-to-3D perception realization, fine motor skills, fulcrum effect modification and the loss of haptic feedback. These surgical skills are not specific to Paediatric Surgery but to all surgical specialties.

As well as the current basis for surgical simulation training, the future directions of research and development in simulation will be discussed.

Conclusion: While significant cardiopulmonary effects of CO2 insufflation were observed in neonatal endoscopic surgery, those effects were temporal. Our data suggests that neonates can tolerate well both laparoscopic and thoracoscopic surgery.

Lapaoscopic Transabdominal Preperitoneal (TAPP) Repair of Strangulated Obturator Hernia

Author: Dr. Aung Lwin

Introduction: Obturator hernia represents 0.07-1% of all hernias and 0.4% of bowel obstruction. Approaches for surgical repair of these hernias include transabdominal, anterior thigh approach and laparoscopic methods. This video demonstrates our experience with laparoscopic transabdominal preperitoneal (TAPP) repair of a case of strangulated obturator hernia.

Method:

Patient background: Our patient is an 84 years old multiparous female who presented with intestinal obstruction. CT scan showed small bowel obstruction due to a strangulated left obturator hernia.

Surgical technique: Laparoscopic approach was chosen for this emergency repair. Laparoscopy showed left obturator hernia with an irreducible loop of small bowel as content. Preperitoneal plane was developed and hernia was reduced meticulously. Strangulated segment of small bowel with perforation was noted. In view of the gross contamination, biological mesh was placed to close the defect. The transumbilical camera port was extended to 3cm lower midline incision. Perforated bowel loop was exteriorized, resected and anastomosis was performed. Post operatively she recovered well without complications.

Discussion and Conclusion: Obturator hernia typically presents in a multiparous, malnourished female in their 70s and above with intestinal obstruction. CT scan is the gold standard in the diagnosis. Out of the various approaches, TAPP allows better assessment of bilateral groin areas and viability of bowel. It has the advantages of being a minimally invasive surgery and concomitant repair of inguinal and femoral hernias. However, laparoscopy is not suitable if excessively dilated bowel loops are obscuring the view. Choice of mesh depends on the presence of contamination.

Laparoscopic Interval Appendicectomy Using Basic Laparoscopic Instruments, A Video Presentation

Professor Moe Myint, Professor & Head, Department of Surgery, University of Medicine, Magway

Background: The first open appendicectomy was done by Claudius Amyand in 1735 and the first laparoscopic appendicectomy was done by Kurt Semm, a German gynaecologist in 1980. Since then, laparoscopic emergency appendicectomy is performed in many centers around the world with good success rate. In Myanmar, routine laparoscopic appendicectomy for acute appendicitis is not recommended because of high cost, longer preparation time for instruments, lack of expertise by junior surgeons and no obvious advantage over open appendicectomy. Current guidelines do not support routine interval appendicectomy.

Video presentation: In this presentation, the author performed laparoscopic interval appendicectomy of 60 years old female who has appendicular mass 2 months ago and the mass did not resolve completely. The author presents how to set up the ports, how to dissect omental adhesions from appendix without bowel injury, how to deal with appendicular artery and mesoappendix using basic instruments, how to tie base of appendix with Roeder's knot and alternative option for Roeder's knot and retrieval of appendix.

Conclusion: Lap interval appendicectomy has its own challenges. Fibrous omental adhesion is one of the main problems and it could be dealt with basic laparoscopic instruments safely.

Difficult Cholecystectomy: A Video Presentation

Professor Moe Myint, Professor & Head, Department of Surgery, University of Medicine, Magway

Background: Laparoscopic cholecystectomy is a gold standard operation for symptomatic gall stones. Acute and chronic cholecystitis are no longer contraindication to LC. But, conversion rate and CBD injury rate are higher. New guidelines for prevention of CBD injury and safety
have emerged.

Video presentation: In this presentation, the author presented laparoscopic cholecystectomy of 46 years old female with frequent episodes of cholecystitis. She had dense fibrous adhesions and even choosing the site of insertion for ports was difficult. Identification of Calot's triangle was difficult too. The author used blunt and sharp dissection, hydrodissection and uses of node of Lund as an anatomical landmark for safety.

Conclusion: Patient's safety is a priority issue in difficulty. In the absence of facilities for peroperative cholangiogram, identification of anatomical landmarks, judicious use of various methods of dissection would help to prevent CBD injury.

Hybrid Endo-laparoscopic Trans-Gastric Resection of Gastric GIST (Video presentation)

Dr. Aung Lwin

Patient background: Our patient is a 95-year-old lady who presented with abdominal pain with severe anaemia. CT scan showed gastro-gastric intussusception with lead intraluminal 5x4cm gastric mass. Oesophagogastroduodenoscopy (OGD) showed intussusception of stomach which reduced with air-insufflation and endoscopic manipulation, revealing a large 5cm pedunculated polyp arising from the fundus, Intussusception was noted again when we attempted for EUS-guided FNA later.

Surgical technique: Trans-gastric excision of gastric polyp with laparoscopic-endoscopic guidance was chosen for this patient in view of her age and the need to avoid major surgery. The stomach was inflated endoscopically. A 12mm balloon port was inserted directly into the stomach. Using the light and vision from the endoscope, an Echelon Flex powered stapler was used to excise the polyp. Further 5mm ports inserted at RIF, left to umbilicus, LIF and lower midline to close the gastrostomy. She recovered well post-operatively. Histology of resected specimen was reported as GIST with mitotic count 4 per 50HPF. Resection margin is clear of tumour.

Discussion and Conclusion: Gastro-gastric intussusception is extremely rare, and can present with abdominal pain, vomiting and severe anaemia. 90% of them have an identifiable lesion as a lead point, which include benign lesions (e.g. GIST, polyp), malignant gastric tumour or anastomosis from previous gastric surgery. OGD and CT scan are the diagnostic modalities of choice. Treatment option depends on the underlying pathology that leads to the intussusception. Hybrid endo-laparoscopic trans-gastric resection is well accepted minimal invasive procedure with favorable oncological outcome in selected cases of intragastric tumours.

Initial Experience of Laparoscopic Liver Resection in Hepatobiliary and Pancreatic Surgery Department, Yangon Speciality Hospital, Myanmar.

Ei Ei Khine, Pyae Pa Pa Kyaw, Sai Saing Wan Kham, Nay Win Nyunt, Lwin Lwin Naing, Tin Myo Thet, Lin Tun Thein, Min Htin, Sai Aung Nyunt Oo, Saw Maldo Thein, Nyi Nyi Swe, Tin Tin Mar

Department of Hepatobiliary and Pancreatic Surgery Department, Yangon Specialty Hospital, Yangon, Myanmar

Abstract

Background: In recent year, minimally-invasive hepatectomy had been demonstrated to be an acceptable approach for both benign and malignant hepatic neoplasms. Laparoscopic liver surgery had a history of slow start compare to other minimally invasive surgery due to initial concern about intraoperative complications of haemorrhage, air embolism and also due to prolong learning curve. Through the pioneering work of high-volume, expert centers, and increasing body of evidence has emerged in recent years confirming the possible advantages of Laparoscopic Liver Surgery. The aim of this study is to evaluate our initial experience of laparoscopic Liver surgery on a variety of parameters during January to August 2017.

Materials and methods: A retrospective single-center case series which was conducted in Hepatobiliary and Pancreatic Surgery Department, Yangon Specialty Hospital for 8 months period. Total 10 cases of Laparoscopic liver resections were done from January 2017 to August 2017. Operative techniques were standardized. Short term outcomes such as immediate and early post-operative morbidity, operation time and hospital stay were evaluated.

Results: Laparoscopic Liver surgery rate was 14 % (ie, 10 out of 73 liver resection) during 8 months period. The average age was 57 (range from 42 to 77 years). Male:Female ratio is 4:6. Among total 10 cases of Laparoscopic liver resection cases within 8 months , 1 case for Laparoscopic liver resection of segment VI + LCBDE and primary repair, 1 case of laparoscopic liver resection for segment VII, 3 cases of laparoscopic left lateral sectionectomy , 1 case of laparoscopic left lateral seactionectomy + non anatomical resection of segment IV B, 2 cases of laparoscopic liver resection segment VI, 1 case of Laparoscopic Rt Posterior sectionectomy and 1 case of laparoscopic liver resection for segment V and VI. Our learning curve took nearly 6 months period. Conversion to open surgery was encountered in one patient who underwent laparoscopic liver resection for

segment V and VI (ie 10 %). The average hospital stays were 8.2 days (range from 6 to 10 days) and zero mortality rate during this study period.

Conclusion: Laparoscopic Liver resection had started in Myanmar only in 2017. Due to the support and guidance of outreach programme of ELSA and hepatobiliary surgical team (Tan Tock Seng Hospital), our learning curve is not too long and can perform laparoscopic liver surgery with the advantages of less intra operative blood loss, less postoperative complications, decreased need for analgesics, faster functional recovery, short post-operative stay and cosmetic benefit. This study is first single center case report series for laparoscopic liver resection in Myanmar and these results have increased the interest in Laparoscopic Liver surgery in our country.

Open Oesophagectomy

Prof. Tin Soe

Abstract

Esophagectomy is conventionally or historically performed by open methods, viz thoracotomy, laparotomy and neck dissection according to various approaches. Ivor Lewis is the most widely practiced approach although it has to open two body cavities. This leads to morbidity and even mortality even in high volume centers. Sweet approach disturbs anatomy and physiology less than the Ivor Lewis does, but limited to very low oesophageal lesions and those in cardia. McKeown approach usually and essentially clears all cancer and regarded as best approach for oesophageal cancer. However, it is even more extensive than the Ivor Lewis. Transhiatal approach is a good one for benign lesions but not recommended to clear nodal metastasis. Nowadays VATS oesophagectomy gains popularity to perform almost all approaches but it is limited upto T3 malignant lesions.

However, many thoracic or upper GI surgeons have to rely on open methods to perform oesophagectomy for both benign and malignant lesions because of technical skill and limited facilities. In addition, majority of cancer patients belong to the advanced stage. Anyway, surgical skill and techniques are evolving to make difficult procedures easy, leading to a stage in which all will be performed endoscopically.

Minimally Invasive Esophagectomy

Aung Myint Oo
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Abstract

The history of esophageal disease and its surgical treatment dates back to 2500 BCE. The first cervical esophagotomy was reported in 17th century and the first cervical esophagectomy was performed by Johann Nepomuk Czerny in latter part of the 19th century. The first thoracic esophagectomy for cancer was performed by Franz Torek in the German (now Lenox Hill) hospital in New York City in 1913. Since then open surgical esophagectomy developed as an acceptable treatment for benign as well as malignant diseases of esophagus.

With the laparoscopic fundoplication performed by Dallemagne et al in 1991, the minimally invasive surgical technique was first adapted into the field of esophageal diseases. Since then, the minimally invasive surgical procedures have been increasingly performed for both benign and malignant diseases of esophagus. The first thoracoscopic esophagectomy was described by Cuschieri et al in 1992 and the first laparoscopic transhiatal esophagectomy was performed by Depaul et al in 1995. Watson et al first described a completely minimally invasive Ivor Lewis technique in 1999. Since then the minimally invasive esophagectomy (MIE) has been popularized and performed increasingly worldwide.

Esophageal cancer is the eighth most common cancer in the world with 456,000 new case diagnosed in 2012. According to WHO statistics in 2014, 8.8% of cancer related deaths in males are due to esophageal cancer which is the 5th most common cause of male cancer death in Myanmar. The incidence of esophageal cancer in male patients was reported to be 11.4 (Age-standardized Rate per 100,000) and was the 20th highest incidence of esophageal cancer in Males in 2012.

Even with the ongoing advancements in medical and surgical treatment have improved the prognosis of esophageal cancer over the years, the overall 5-year survival rate of patients with resectable esophageal cancer remains disappointing. Surgery is still the mainstay of treatment and esophagectomy remains one of the most complex surgical procedures with high morbidity (20-40%) and mortality rates reported to be as high as 23%.

Over the past decades, minimally invasive esophagectomies (MIE) have been reported to have acceptably reduced procedure-related morbidity while not compromising disease free survival rates. MIE can be safely performed in selected patients and even those patients considered so high risk for an open surgery. MIE has also been shown to result in shorter ICU and hospital length of stay, decreased blood loss, and operating time.

In conclusion, MIE has the potential to yield precious advantages over open surgeries in terms of decreased pain, less morbidity and faster recovery without compromising the overall oncological outcomes in suitable esophageal cancer patients.

Laparoscopic Paraduodenal Hernia Repair

Dr. Hla Myo

Abstract

Para duodenal hernia is rare disease and is basically congenital origin due to malrotation of mid gut and impaired fixation of mesentery. It is one of the most common forms of internal hernia that complicate intestinal obstruction up to 50% during life long period. Left sided Para duodenal hernia is more common. Clinically very difficult to diagnosed and need to pay high index of suspicion. The patient is 39-year-old lady presenting with signs and symptoms of gastric outlet obstruction (GOO) and she had experienced of repeated similar attack for which repeated hospitalization and treated conservatively as GOO with no definite cause for long time. Diagnosis was made by CT imaging preoperatively and laparoscopic para duodenal hernia repair was done with obliteration of herniated space. Her recovery was smooth without complication and no more recurrent symptoms in follow up.

Enhanced Recovery Programme in Laparoscopic Colorectal Surgery

Dr. Kyaw Htet

Background: Laparoscopic colorectal surgery may improve short-term outcome without compromising long-term survival or disease control. Recent evidence suggests that it is beneficial for laparoscopic colorectal surgery when perioperative care is optimized within an enhanced recovery programme.

Methods: Between July 2016 and June 2017, 18 patients underwent laparoscopic colorectal surgery at No.1 DSGH, Mingaladon and No.2 DSGH, Nay Pyi Taw. All were entered into an enhanced recovery programme. Length of hospital stay, early return of bowel function, perioperative morbidity and surgical site infection were reviewed.

Results: Length of hospital stay after laparoscopic colorectal surgery was 6 days on average. Return of bowel function was noted on second postoperative day. Morbidity was noted in 4 cases (post-operative chest complication in 2 cases, urinary tract infection in one case and prolonged ileus in one patient). Surgical site infection occurred in 2 cases, both are superficial SSI.

Conclusion: Enhanced recovery program is safe, effective and applicable for Laparoscopic colorectal surgery.

Our Treatment Results of Intraventricular and Paraventricular Tumor: Comparison Between Adult Cases and Pediatric Cases

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We analyzed our treatment outcome of intraventricular and paraventricular tumors. Regarding treatment strategy, we performed endoscopic biopsy for tumor and endoscopic third ventriculostomy (ETV) for hydrocephalus, as an initial operation. This strategy was in common between adult and pediatric cases. Regarding duration of the patency of ETV stoma, there was no statistical significant difference between adult and pediatric cases. Regarding histology, many cases were chemosensitive. This point was also in common between adult and pediatric cases. However, compared to adult cases, pediatric cases were

more likely treated by tumor removal, based on histological results. Comparing between adult and pediatric cases, we would like to show our results and mention tips for management of intraventricular and paraventricular tumors in this presentation.

Practical Usage of Endoarm for Various Intracranial Diseases

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These days, endoscopic providers have released some new types of rigid neuroendoscopes. Toward the development of minimally invasive surgery, we applied EndoArm which is categorized as rigid endoscope, to various intracranial diseases, such as, hydrocephalus, brain tumours, intracranial arachnoid cysts, infection, paediatric diseases, and so on. We experienced over 140 patients who suffered from skull base diseases, intraventricular tumours, hydrocephalus, intracranial infection, and CSF leakage, treated by EndoArm (Olympus, Japan). EndoArm yields some benefit for these endoscopic surgeries. For example, using this endoscope, we can use both hands freely, and fix it anywhere you want. In addition, small craniotomy or corticotomy can be performed when using this endoscope because of its good visibility for dead angle. In this paper, we show some representative cases to which EndoArm was applied in our institution.

Current Situation of AS Treatment and Role of Heart Team: Situation in Japan

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After the introduction of TAVI in Japan, the Heart Team concept has spread widely and become very important in the treatment of AS patients.
Since reimbursement approval of SAPIEN in 2013, followed by CoreValve in 2016, nearly 7000 patients have been treated with TAVI in Japan.
In order to perform TAVI in Japan a center must be certified by the TAVR Association of Japan. Currently, there are 106 institutes certified to perform TAVI.
To be certified by the committee one of the conditions is for the applying institution to have a well-balanced, functioning "Heart Team" that can manage patient care before, during, and after the TAVI procedure. In order for this to happen it is essential that the cardiac surgeons and interventional cardiologists work closely together in a collaborative manner; especially since the indication for TAVI in Japan is currently limited to patients who are considered to be inoperable or high risk for surgery.
Originally the role of the surgeon was to lead the trans-apical and direct aortic cases while cases performed via the trans-femoral approach were done by the cardiologists. With the on-going improvement in TAVI devices and subsequent increase in the prevalence of the trans-femoral approach, however, this division of roles is becoming less common.
As the line between the roles of surgeons and cardiologists becomes more blurry the "Heart Team" approach will become even more important in making a fair in selecting TAVI for AS patients; which is very good for patients.

New Strategy for Aortic Dissection with Endovascular Stent-Graft Technologies

Toshihisa Asakura, M.D., Ph.D.
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Department of cardiovascular surgery, Saitama medical university, International medical center, Japan

Aortic dissection is the most common aortic catastrophe, with dynamic pathology and high rates of morbidity and mortality if left untreated. The incidence of aortic dissection in Japan is one of high rate in the world. Over the last 10 years, the landscape in the management of aortic pathology has changed significantly. The treatment paradigm for aortic dissection is changing in a new era with the endovascular stent-graft technologies.

This presentation focus on recent advances in the surgical and endovascular management of aortic dissection. Especially, I would like to introduce the open and modified open stent graft techniques which have been added as adjuncts to the surgical management of type A dissections. A very key point of this technique is having a clear understanding of post-procedural remodeling of the dissected descending aorta to reduce the risk of re-do surgery and improve long-term outcomes. Furthermore, I would like to introduce endovascular management of complicated and uncomplicated type B aortic dissection. TEVAR should be applied to High-Risk uncomplicated cases with the predictors of aortic growth and suitable anatomy, to decrease the late aortic interventions and mortality in order to promote aortic remodeling.

To avoid a nightmare among your patients from a silent killer for the cardiologists and cardiovascular surgeons the possible treatment strategies among individual cases should be known.

Laparoscopic Urology at Nay Pyi Taw General Hospital

Thet Ko Aung, Khin Myat Swe, San Min Oo, Win Min Htet, La Min Win, Shwe Win
Dept. of Urology, Nay Pyi Taw General Hospital (1000 bedded)

In urology, most of the operations are performed by endoscopic means and some are performed by open procedures. With advance in technology, Minimal Access Surgery (MAS) such as percutaneous nephrolithotomy (PCNL), retrograde intrarenal surgery (RIRS) and laparoscopy become popular and replace most of conventional surgeries.

Laparoscopic urological operations were initiated in 2016 at Nay Pyi Taw General Hospital. At present we do laparoscopic procedures in the field of reconstructive urology, uro-oncology, uro-gynaecology and stone surgery. Laparoscopic operations performed were laparoscopic nephrectomy, laparoscopic partial nephrectomy, hand assisted laparoscopic radical nephrectomy, laparoscopic nephro-ureterectomy, laparoscopic pyeloplasty, laparoscopic pyelolithotomy, laparoscopic marsupialization of renal cyst, laparoscopic ureterolithotomy and laparoscopic repair of vesico-vaginal fistula. Laparoscopic operations provide satisfactory clinical outcome with less morbidity, shorter hospital stay and early convalescence.

Variety of laparoscopic procedures we had done is quite satisfactory but case volume is very small because there are so many limitations such as limitation of facility, limitation of workload and limitation of operation day. Anyway, we can do laparoscopic operations and overcome some difficulties. I hope more and more laparoscopic operations will be performed with solution of limitations.

Principles of Flexible Endoscopy

David Tolley

The principles involved in teaching and learning any new procedure in surgery are the same regardless of the nature of the procedure and its application to patient management.

These principles include following a curriculum of learning defined by the academic or professional body responsible for ensuring that agreed standards of care are met at the highest level of governance. It therefore defines the requirements of theoretical knowledge and the level of practical skills and their subsequent assessment to ensure that highest possible standard of patient care is met.

For flexible endoscopy, this process may be overseen by a multidisciplinary group of physicians and surgeons working together to develop an agreed set of standards.

Practical training in flexible endoscopy will begin by ensuring that the student possesses a detailed knowledge of the equipment used and its care, indications for the procedure, a knowledge of applied endoscopic anatomy, the normal endoscopic appearances and common pathology.

Attendance at approved basic and advanced level skills courses must be complemented by opportunities for the student to gain further practical clinical experience under the guidance of an accredited endoscopic trainer. Mandatory 'refresher' courses should also be offered to established endoscopists.

A key aspect of ensuring that standards are met and maintained lies in ensuring that the trainee endoscopist's competence is assessed at the end of each training course and also in the work place (WPBA) by direct observation of procedures by the trainer (DOPS). Trainees should also record procedures performed in a logbook which will be reviewed during an annual appraisal process.

An example of role of an electronic logbook and DOPS will be presented for discussion and the experience of WPBA assessment and annual appraisal in one surgical specialty will be presented. Delegates will be invited to consider the relevance of this approach to training in flexible endoscopy in all surgical disciplines and to discuss the potential value of a national structured training programme for endoscopists in Myanmar.

PCNL: Mandalay's Perspective

Prof. Min Thu, Department of Urology, Mandalay General Hospital

Objective: To review PCNL cases in the Department of Urology, Mandalay General Hospital

Material and Methods: The operative notes of PCNL cases which were performed in the Department of Urology, Mandalay General Hospital from 2015 and 2017 (up to 31st August) were retrospectively analyzed.

Results: A total of 147 PCNL cases (including 5 cases of mini-PCNL) were carried out in 2015, 255 cases (including 13 cases of mini-PCNL) in 2016 and 156 cases (including 13 cases of mini-PCNL) in 2017 (up to 31st August). All cases are performed in prone position. Access to the renal collecting system is achieved by urologists with the guidance of C rotational fluoroscopy in almost all cases. Percutaneous nephrostomy tubes are placed in all cases and some have double J stents. Minor calyceal bleeding is the most common complication and 1 patient died from septicaemia in 2015. Overall stone free rate is 85%.

Conclusion: PCNL is a minimally invasive procedure with a good stone-free rate and has become the routine procedure in Mandalay General Hospital.

Our Surgical Procedure of Laparoscopic Gastrectomy for Gastric Cancer

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Gastric cancer is the third most common cause of cancer death in the world.

In Japan, the treatment strategy for gastric cancer such as the range of appropriate lymphadenectomy is defined by Japanese Gastric Cancer Treatment Guideline (ver. 3). The number of laparoscopic gastrectomy has been increasing in Japan, even though the guideline defines this surgery is still “an investigational treatment”. In this presentation, we will show our surgical procedure with video clips and show clinical outcomes. In our institution, the operator performs all procedure of laparoscopic gastrectomy from the patient’s right side. Lymphadenectomy, especially in the suprapancreatic area, is performed after preoperative simulation with 3D-CT vascular anatomy. Reconstruction is usually performed with either Roux-en-Y or Billroth-I (Delta anastomosis) in distal gastrectomy, and Roux-en-Y (Overlap method, “inverted T shape”) in total gastrectomy. In addition, we have tried staging laparoscopy and neoadjuvant chemotherapy for advanced gastric cancer in recent years. In conclusion, laparoscopic gastrectomy can be safely performed and is also a useful treatment for advanced gastric cancer combined with appropriate chemotherapy.

Percutaneous Biportal Endoscopic Spine Surgery for Lumbar Diseases: A Technical Note and Preliminary Clinical Results

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Abstract:

Traditionally, lumbar spine diseases are treated with an open decompressive laminectomy, foraminotomy, or fusion with or without discectomy. But extensive soft tissue dissection caused paravertebral muscles atrophy and might result in back heaviness and long-term pain. Resection of interspinous ligament for better surgical vision also led to instability, and it would require instrumentation Recently, minimally invasive spinal surgical methods have developed to improve preservation of the surrounding normal anatomical structures, such as the muscles and ligaments. There have been several trials of minimally endoscopic spine surgery to treat lumbar spine diseases; however, technical barriers including stiff handling of an endoscope and limitation of instruments available could only be undertaken by experienced endoscopic surgeons. There has been the recent introduction of unilateral approach - biportal endoscopic spinal surgery (UBE) to minimally invasive spine surgery (MISS) as it has several benefits including excellent magnification and illumination.

35 cases of UBE were performed for treating of various lumbar spinal diseases from January to May of 2017 in Yangon Orthopaedic spine centre. Our inclusion criteria were as follows: single-level lumbarspinal stenosis or prolapse disc with neurological intermittent claudication or radicular leg pain refractory to conservative management for at least 12 weeks, functional status was assessed by Oswestry Disability Index (ODI), visual analog scale (VAS) score for leg pain upto postoperative 20 weeks, Preoperative and postoperative ODI and VAS at final follow-up were compared. Average age was 43.0±11.3 years (range, 23–65 years),20 cases were lumbar disc herniation (LDH),13were lumbar spine stenosis (LSS) (stenosis 9, stenosis with LDH 4) and mild spondylolisthesis with stenosis were 2cases. Average operation time for LDH was 110.7±33.6 minutes, and stenosis with LDH was 128.6±14.7 minutes. Average ODI score was improved from 67.2 ± 11.7 to 24.3 ± 8.5 and visual analog scale (VAS) score for leg pain was reduced from 8.3 ± 1.1 to 1.4 ± 0.6.

After the 12th case in LDH (the 35th case in total), operation time remained constant nearly at the average time. Prolonged operation times even in later

cases of LSS were mainly due to blurred vision by epidural bleeding. Overall complications during the early learning period included 1 cases of dural tear at the third and 1 case of neuropraxia at the fifth. There were no instances of symptomatic hematoma or wound infection. For management of a dura tear in UBE, there has not yet been a recommendable technique. But a few pieces of gelfoam laid on the site piece by piece may be remedy, as dural repair is yet impossible with the current instruments. In my case of dural tear, it was controlled after 7days of conservative management, there was no cystic or fluid collection seen on postoperative MRIs. Fluent outflow of saline, control of epidural bleeding for a clear view, and successful flavectomy with angled curettes were the strategies in reducing complications with the new surgical technique.