Opinion

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Analysis of Conventional Laparoscopic Resection

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Description

Low anterior resections are increasingly performed laparoscopically for rectal cancer. Recently, natural orifice specimen extraction surgery (NOSES) has been reported as an alternative approach without additional incisions or extensions. In this study, we aimed to evaluate the safety and feasibility of NOSES by comparing the short-term outcomes with those of Conventional Laparoscopic Resection (CLR) in a multicenter retrospective study from China and Russia.

Conventional Laparoscopic Resection

This retrospective multicenter study was conducted in three centers between January 2015 and December 2017. The three chief surgeons had experience with more than 800 laparoscopic surgeries. Generally, the main indication for performing a NOSES rectal resection was the technical ability for this approach. During the study period, 412 patients underwent CLR and 356 patients underwent laparoscopic rectal resection with the NOSES approach, including 310 transanal and 46 transvaginal extractions. The demographics and baseline clinical characteristics of the patients. No differences were detected between the CLR and NOSES groups in gender, mean age, American Society of Anesthesiologists score, TNM stage, and tumor location.

The presence of robots in the hospital system has grown impressively, despite steep entry costs. Nowadays, the popular perception is favorable to the use of surgical robots and the hospitals that have them. Correspondingly, an institution looking to promote minimally invasive surgery capability needs to have a robot. The market is currently dominated by the da Vinci, and approximately 5000 active systems perform more than a million robotic surgeries each year. American Association of Endocrine Surgeons national general surgery case logs from 1989 through 2019 were reviewed. The numbers of individuals completing residency and the mean and median number of endocrine surgery cases by type and by level of operating resident surgeon were abstracted from annual data and analyzed.

The continuous growth of robot-assisted surgery depends on the concept that they will become essential to operative environments in the time to come, in a way not dissimilar to laparoscopic and endoscopic techniques. Because the da Vinci is the most commercially successful model, it also sets the standard for improvement of the current weaknesses of robot-assisted surgery. Core Procedural Competencies (CPCs) in hand surgery have been previously described. However, it is unknown whether plastic surgery residents receive sufficient operative experience with these procedures. This study aimed to determine whether Canadian plastic surgery residents are receiving adequate exposure to CPCs in hand surgery during residency training.

Core Procedural Competencies

Hand surgery case logs recorded by graduating plastic surgery residents at 10 Canadian English-speaking training programs between 2004 and 2014 were reviewed from 3 databases. For each CPC in hand surgery, perceived resident role and self-competence scores were collected and analyzed. Core procedural competencies encompass Core Essential Procedural Competencies (CEPCs) and nonessential procedural competencies. We identified colorectal surgery patients across five collaborating institutions. We recorded preoperative opioid exposure, inpatient opioid use, and persistent use 90–180 days after surgery.

Procedural competencies in plastic surgery were previously established using a modified Delphi technique. In that study, an expert panel of 31 Canadian plastic surgeons categorized plastic surgery procedures into 1 of 5 categories (core essential, core nonessential, non-core experience, non-core fellowship, and not in scope), reviewing each procedure iteratively through 3 different rounds. The ARCH Database was queried for all elective aortic arch replacements with and without aortic root replacement using moderate hypothermic circulatory arrest and ante grade cerebral perfusion from 2000 to 2015. Propensity score matching analysis was used to balance covariates and a logistic regression model was created.

The opioid epidemic is currently one of the most challenging public health crises facing the United States. The United States department of health and human services has recently elevated the opioid epidemic to the level of a public health emergency. In 2016 alone, approximately 42,000 people died from opioid overdose and an estimated 40% of overdose deaths involved a prescription opioid. Surgeons wrote approximately 10% of the 289 million opioid prescriptions in the US in 2012, and 36% of all

prescriptions written by surgeons were opioid pain medications. These prescription opioids catalyze the epidemic by not only putting individual surgical patients at risk, but also their local communities, as 69% of people that have abused opioid medications have received the medication from a friend or relative, most of whom were prescribed the medication by a physician. Amongst surgeons, gastrointestinal surgeons are the third highest prescribers of opioids, after orthopedic surgeons and neurosurgeons, and the rate of persistent opioid use after colectomy has been reported to be as high.

These findings have been corroborated in the literature, as opioid use prior to surgery has been shown across multiple studies to be associated with an increased risk for persistent use long after surgery. A handful of studies have implicated increased quantity of perioperative opioid use as a risk factor for persistent postoperative use however many of these studies include opioid use during the weeks before surgery as a component of the calculation, which may be out of the surgeon's control. Interestingly, there has been little focus on patterns of postoperative inpatient use and any association it may have with either preoperative opioid exposure or the risk of persistent opioid use post-discharge. Importantly, approximately 99% of patients undergoing elective inpatient surgery are administered opioids during their hospitalization.

Global surgery is an emerging academic discipline that is developing in tandem with numerous policy and advocacy initiatives. In this regard, academic global surgery will be crucial for measuring the progress toward improving surgical care worldwide. However, as a nascent academic discipline, there must be rigorous standards for the quality of work that emerges from this field. In this white paper, which reflects the opinion of the global academic surgery committee of the society for university surgeons, we discuss the importance of research in global surgery, the methodologies that can be used in such research, and the challenges and benefits associated with carrying out this research. In each of these topics, we draw on existing examples from the literature to demonstrate our points. We conclude with a call for continued, high-quality research that will strengthen the discipline's academic standing and help us move toward improved access to and quality of surgical care worldwide.