The Royal College of Surgeons of England

GUEST EDITORIAL

Ann R Coll Surg Engl 2010; **92**: 271
doi 10.1308/003588410X12664192076179

Guest Editorial

When David Rosin and the late David Dunn independently visited Petelin in the US in 1990 and invited him to demonstrate laparoscopic technique in front of a large audience of experienced surgeons in London, a new era of minimally invasive surgery dawned. As with every other medical/surgical invention, enthusiasts rushed around with this new hammer looking for nails to hit. In the period 1990–1995, we taught ourselves with a steep learning curve. Just as in the early days of UK cardiac surgery which I had experienced as a registrar, frequent serious complications occurred.

Surgeons who knew their anatomy well and had carried out 1000–2000 open hepatobiliary procedures came face to face with two dimensional images, indirect tissue touch, and the risk of technical equipment breakdown. Prophets of the new technique implied that lack of aptitude in laparoscopic method indicated inferior operative skills. However, wise older surgeons reverted to trusted open techniques both in gallbladder and hernia surgery. Unfortunately, trainees were not afforded this luxury.

There was a large cohort of surgeons 10–15 years ago who were not refuseniks. They inspected the gallbladder operative field with the laparoscope and, if they had any doubts about the efficacy or safety of a keyhole operation, retreated in good order after a 10-min inspection and proceeded to a mini-laparotomy. This was usually completed within an hour in the best interests not only of the index patient but those following in the operation list.

There can be no question that the authors of the paper[1] in this issue on medicolegal implications of laparoscopic technique have provided a signal service. Be warned: surgeons writing legal reports, and lawyers with a built-in adversarial bent, will quote this paper in future legal proceedings. The conclusion of the article by Scurr *et al.*[1] has the firm statement: 'bile duct and major vascular injuries are almost indefensible'.

In the present climate of laparoscopic surgery, it is important to realise that the gold standard gallbladder operation is the procedure that 'does no harm'. Senior surgeons who supervised 100 cholecystectomies a year for 20 years prior to the laparoscopic era can bail out of difficult ''keyhole' procedures confident that they are in comfortable territory having opened the abdomen. Unfortunately, both current trainees and younger consultants have not had this experience. For them, conversion is a move from the laparoscopically difficult or impossible to a procedure of which they have minimal experience. Young surgeons faced with unexpected problems such as a cholecystoduodenal fistula, anomalous porta hepatis anatomy, a malignant gallbladder or unanticipated hepatic flexure colonic disease should be advised to take the following steps:

1. Decide whether they can deal with the operative findings by an open operation based on previous experience in this area.
2. Seek advice from an available senior colleague. In the light of that advice, open the abdomen with mentor assistance or alternatively abandon the procedure and reschedule the patient either for operation with a colleague in the same institution or, if there is the suspicion that the underlying problem is malignant disease in the hepatobiliary tract, refer the patient to a tertiary centre.

A patient I treated for breast cancer recently related how she had undergone a 4-h laparoscopic cholecystectomy. When one takes into account the risk of bile duct injuries and the other complications described in the article by Scurr *et al.*,[1] one also has to keep in mind how a Court would view death from pulmonary embolism or other consequence of protracted surgery when the independent medicolegal report identified this problem in the anaesthetic record of the case.

Laparoscopic procedures when they go wrong are as indefensible as a non-essential cosmetic operation which results in serious harm or death of a patient. Due consideration should be given to ensuring that trainees seeking to use laparoscopic techniques in their professional career have an appropriate experience of the safe default position of traditional open surgery and that they acquire the good judgement to know when to use that approach.

Acknowledgement

The opinions expressed in this editorial are those of the author.

Reference

1. Scurr JRH, Brigstocke JR, Shields DA, Scurr JH. Medicolegal claims following laparoscopic cholecystectomy in the UK and Ireland. *Ann R Coll Surg Engl* 2010; **92**: 286–291.

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