AMASI

AMASI Newsletter

JANAUARY 2021

(Association of Minimal Access Surgeons of India)

FROM THE PRESIDENT'S DESK

Warm greetings from Imphal, Manipur and happy New Year greetings to each and every AMASI member.

It gives me immense pleasure to write this message from the desk of the President, AMASI.

First allow me to express my heartfelt gratitude to all the seniors, executive members of AMASI and each and every member of AMASI to have reposed the responsibility of President, on me, to carry forward the mantle of the services of AMASI for the term 2020 to 2022. I remain deeply humbled.

With the Covid pandemic of 2020, as with every organization and individual, there have been formidable changes in the functioning of AMASI. The scheduled skilled courses and annual conference AMASICON 2020 had to be converted to virtual meets. But with the guiding inspiration of founding president Dr C Palanivelu, and the positive outlook of

all its leaders, AMASI converted the adversity into a great opportunity for surgeons across the world, to learn surgeries without having to travel. With the record attendance and views of AMASICON 2020 for 3 days, it became clear that we have the capacity to convert all setbacks into advantages. I congratulate all the senior leaders of AMASI including the then President, Dr B S Pathania and Secretary Dr Kalpesh Jani, executive members and faithful AMASI members, to have left an indelible mark in the history of surgical skill and knowledge dissemination, in such a successful manner.

With the steep upward trend of AMASI activities during this period of pandemic, I have been handed over the exciting task of disseminating skills, knowledge and camaraderie to surgeons of more extended areas within the country and beyond. Fortunately we are beginning to see the ebb of the Covid pandemic in India. Also the much awaited vaccinations are going to take place soon. I foresee revitalized vigor amongst AMASI office bearers and members and fruitful activities in the coming years.

At the end of the tenure of 2 years I would like to ask myself few questions.

First, has AMASI, true to its motto of MAS for masses, been able to develop more surgeons in each and every town of India towards achieving its goal of making the benefit of laparoscopic surgery accessible to each and every individual in the country, whosoever needs the service?

Second, has AMASI been able to improve the skills of every laparoscopic surgeon in the country, such that, whatever laparoscopic surgery they are performing, will be technically safer for the patient?

Third, has AMASI been able to imbibe into its ranks the ever improving evidence based procedures which are evolving with passage of time? For instance, if robotic surgery gives more benefit to the patient and surgeon, has AMASI done enough to train more surgeons in robotic surgery?

Fourth, with emerging increased benefits of hybrid procedures of per-operative endoscopy and simultaneous laparoscopic surgery, has AMASI been able to train more surgeons to equip them with basic skills of endoscopy?

Fifth, has AMASI been able to spread its fraternity and brotherhood to the neighbouring countries adequately? Have all steps been taken to ensure that surgeons of the neighbouring countries and beyond, have been exposed to the skills of the highly skilled surgeons of AMASI such that they are inspired to do more advanced laparoscopic surgeries in their own countries. Also has AMASI done enough to learn from highly skilled learned faculties of the world so that our own surgeons improve in delivering the results?

Sixth, and last, has AMASI done enough to increase the confidence in its members and prospective new members as regards the benefits of being in the association? Will being a member of AMASI translate to becoming not only a more successful laparoscopic surgeon but a compassionate human being, becoming the pride of his/her community and that of the country?

To all the above questions I would like to answer in a confident affirmative. But to make it happen I beseech each and every member of AMASI to walk with me towards our common goal.

I sign off here with confidence that my call will not go in vain and that AMASI will emerge as the most vibrant minimal access surgery organization in the world.

Long live AMASI.

From the Desk of the Hon. Secretary

Dear esteemed members,

My sincere note of appreciation and gratitude for accepting me as Honorary Secretary of AMASI. We all adore our beloved association for its leadership in scientific field and propagation of the minimal access surgeries to all corners of our country.

Our founder President, Dr. C. Palanivelu who is the undisputed world leader in MAS, started AMASI in 2003 with the philosophy of MAS for Masses. We could not have achieved this height without the hard work and dedication of the trailblazer Palanivelu sir, who worked tirelessly from day 1 to make it today. We must swear allegiance, my friends, to keep the ball rolling through training courses, live workshops and high scientific content CME. In the coming years, we must commit to make more new members, train young surgeons and to elevate the stature of AMASI to a distinct entity in the field of minimal access surgeries.

Hopefully, we will be freed from the clasp of pandemic very soon; till then wear MASK and avoid unnecessary travel and physical gatherings.

Thank you again and wish you all, a very happy new year. Long live AMASI.

IN THIS ISSUE

Gurubhashayam

Prof. K. Rajagopal Shenoy reminisces his long and eventful journey in the academic world and introspects on his achievements, lessons learnt and future aspirations.

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Guideline Series

Prof. Deborshi Sharma and his collaborators present the guidelines for laparoscopic cholecystectomy

Writing a Scientific paper

Prof. Vikram Kate starts a new series from this issue. In this article, he describes in detail how to take the first step in academic publishing – the case report.

Hobby Corner

Prof Saibal Mukherjee shares evidence of his passion for travelling and photography.

Plus the regular features like:

- MAS Masti
- Upcoming events update
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Gurubhasyam

- Dr K Rajgopal Shenoy

From Teacher to Guru- Where am I now?

Long way to go…..

Dr K Rajgopal Shenoy, MS,FRCS
Professor of Surgery-Former associate dean of academics
KMC Manipal (Unit of Manipal Academy of Higher Education-Deemed to be University)
Karnataka, India.

His former PG student and currently Principal of KIMS College, Prof, Ishwar Hosamani has the following to say about Prof. K. Rajgopal Shenoy: "A Prolific teacher, par excellence, great Surgeon, Singer, Chess player and more than that, a good human being. Prof. K. Rajgopal Shenoy is Professor and former head, Department of Surgery and ex-Associate Dean, Kasturba Medical College (KMC) and Consultant Surgeon at the associated KMC Hospital, Manipal Academy of Higher Education(MAHE)-Deemed to be University, Manipal. I know him since my P.G days and used to hear his famous bed side teachings which were very popular and his audio and video tapes for teaching UG's and PG's. His is a vibrant and innovative multifaceted personality. A born-leader and loved by his students, colleagues and friends, it's hard to find him alone. He constantly features at all the academic and cultural activities of the institution."

The mediocre teacher tells. The good teacher explains. The superior teacher demonstrates.The great teacher inspires – These are golden words by William Arthur Ward. Mr. Arthur Ward was an American who published many inspirational quotes and poems. Yet, what do you call a teacher who is much above this? Our Sanskrit scriptures written thousands of years ago define different levels of teaching, as follows:

- A teacher who gives information - Adhyapak.
- One who imparts knowledge with information –Upadhyaya
- One who imparts skills is-Acharya
- The one who is able to give deep insight into the subject –Pandith
- The one who has a visionary view on a subject and teaches you to think in that manner is called Dhrishta
- The one who is able to awaken wisdom in you, leading you from darkness to light is known as Guru…

Let me pen down my journey from Ballari to Manipal and see what I am today and where I stand. During my good undergraduate days (1977-1983) in Govt Medical College, Bellary (Now Vijayanagar Institute of Medical Sciences, Ballari) and my post-graduate training at Kasturba Medical College, Mangalore (1983-1986), we had excellent teachers in all disciplines, but a few of them made a lasting impression on me. I realized that one thing that was common to all these people was their love for teaching. Prof. RHN Shenoy, a

father figure, would explain the nuances of Surgery to groups of students. He would conduct clinical case discussions with dedication, precision and facts. He could use both his hands simultaneously to draw the renal system on the black board or on paper (1979-1980). We were all obviously very impressed at that tender age. Imagine Prof. C.R. Ballal, way back in 1984, carrying a bottle with gall stones and discussing about stones and other things! The witty and brilliant clinician Prof.M. Srinivasan used to diagnose cases with great accuracy based on just the clinical findings. I decided to join a medical college as a teacher, following the footsteps of my role models. This is the first lesson I learnt.

Fig.1. Prof RHN Shenoy, Principal, Govt Medical College, Ballari.

Fig2: Prof. M. Srinivasan and

Fig 3:Dr.N Rajan, Dr. Santhosh Pai, Prof. C R Ballal - Two Brilliant clinicians Dr. Sampath Kumar, Dr. Pradeep Rebala and teachers who inspired me to be a (1990) teacher during my postgraduate days. (2016)

Lesson 1: Let me follow the footsteps of my role models from undergraduate and post graduate teachers.

Inspired by my teachers, after acquiring my Masters in Surgery, I joined Kasturba Medical College, Manipal on December 1st 1986 as Lecturer (Registrar) in Dr. Anand Rao's unit, reporting to Dr. N. Rajan.

With bubbling enthusiasm and energy at 26 years of age, I was given the responsibility of taking classes for nurses and dental students. With a simple blackboard and with no mike, I started my theory classes, first for nurses, then for 3rd year BDS students. Appreciation of my classes first came from nursing students between 1986 to 1988 which was a kind of stimulus for a teacher. I taught then in a way that they wanted, and not in a way I want… This was the 2nd lesson I learnt from teaching nurses.

Lesson 2: Teach what students want, not what you want.

I started teaching more than what they were generally taught. Slowly, final year MBBS students started joining dental batch after they completed their clinics. Clinical discussion goes well if attendants also participate. I realised very early and started calling students by their names, started asking questions and gave them more chance to interact. I could realize that students were liking my clinics and I started realizing my strength. Everyone has hidden potential but you need to realize this potential and start working on that. This is the third lesson that I learnt and realized that teaching in a medical college is my area of interest.

Lesson 3: Try to understand your potential early in your career – teaching, operating or both, or research.

Clinical teaching in a medical college cannot be done without reasonable number of patients. Kasturba Hospital, Manipal gives ample opportunity to develop clinical wisdom to everyone. One has to make use of this opportunity to acquire skills. I was lucky to be posted under Dr. Anand Rao. He had a good number of patients who came specifically asking for him; it showed his ability A thorough gentleman, he is a kind hearted surgeon, who performed neat surgery, with a lot of wit, wisdom and sense of humour. My first 2 years as a young surgeon, from December 1st 1986 to December 31st 1988, were very memorable. He laid down the foundation stone of my growth at KMC Manipal. He looked after me so well that I decided to stay in Manipal, in the department of surgery which was like family. He made me to do my first thyroidectomy and then, many other surgeries. He was the first person who instilled a sense of humourin me. As a good leader, he could get the work done without shouting or ordering his assistants. The 3rd important lesson I learnt was from
Dr. Anand Rao, that one must always encourage the juniors/assistants in the institution or for that matter anywhere. He let me develop such leadership qualities. In the subsequent years, working and learning in the department was a pleasure with Dr. Sampath Kumar, Dr. Ramchandra L, my classmate at Ballari, Dr. S. S. Prasad and Dr. Gabriel Rodrigues. Dr Rodrigues specially encouraged me to publish articles. We attended most of the conferences together. If you want to grow in institution or in a private set up, you have to attend conferences, workshops and publish articles (4th lesson).

Fig 4: Dr. B H Anand Rao, Dr. Capt. Ramchandra Dr Gabriel Rodriguess and Dr. S S Prasad

Lesson 4: Always encourage, never discourage!You can get the work done for which you do not have to treat your colleague rudely and in a harsh manner. Attend all possible knowledge-sharing platforms.

Rotating staff to work in different units is a common practice in all medical colleges.Thus a rotation of 6 months each in 4 units – Chiefs being Prof. N. Rajan, Head, Prof P. K. Jena, Late Prof. M.N. Nayak and Prof. Diwakar Shenoy, again consolidated my surgical skills and teaching abilities. Slowly, I took on more responsibilities during these 2 years. I did not ignore teaching because I had become relatively senior. Surgery department was like a family with everyone working for patients and students. Learning has no end. One must refer as many books and journals as possible. I learnt not only surgeries but also a few soft skills which are not taught during study period. I could watch and learn the sharp scissor dissection of Dr. N. Rajan for abdominal cases, a very personal approach from Dr M. N. Nayak, go-getter attitude of Dr P. K. Jena (He had come from AFMC Pune) and cool and calm approach while treating patients from Dr H. Diwakar Shenoy. I also had a decade of association with Dr. Rebala Pradeep in Manipal as a family friend, who demonstrated my first laparoscopic cholecystectomy before he left for Vijayawada. You can learn from your seniors, juniors and even from your students. (5th lesson)

Fig. 5: (Late) Dr. N. Rajan at Hyderabad Surgical Gastroenterology Conference in 2014

Lesson 5: Learning is infinite and has no end. Observe your seniors and learn. Observe how they work, how they talk to patients, nurses or colleagues from other disciplines.

The next 7 years (1991-1998) was an important period during which I got a chance to work for a long period of 7 years under Prof. Upendra Santhosh Pai. He was trained by Prof N. Rajan, and so, was doing and was interested in doing more GI cases. More importantly, he taught me the basic steps of gastric pull up, esophageal devascularisation (Sugiura-Futagawa) and a few more surgeries. I also started doing them. These 7 years were yet another memorable posting. Prof. Santhosh Pai gave me complete freedom in the unit but with responsibility asa teacher, a surgeon and as an organiser.I could get maximum surgical wisdom from Dr U. Santhosh Pai. He encouraged me to take more clinics, allowed me to do more surgeries and permitted me to attend many conferences and workshops. A major development happened during this time: he encouraged me to take photographs of various clinical patients, told me to document and compile them. During these 7 years, the students started attending my clinics from all over after they finished their regular postings. Why did they attend? Because I gave them more than what others gave, I made it simpler than what others would have done or might have complicated further. Also, I always encouraged them rather than ridiculing them. This was also a period wherein I could watch, assist and guide postgraduates in the operation theatres. In addition to operative skills, this was the time I tried to educate them about common issues faced during reguar rounds. When a PG said, 'Sir, the patient has fever after 1st day of Lap chole', I would ask, 'Why is the patient having fever ? What type of fever is it? When did you notice it? Who have you informed? What did you do?' This is the way of learning. Success does not depend upon knowledge alone but also upon how you have applied the knowledge. This is wisdom. Even today I try to correlate and impart wisdom in students and junior staff members(6th lesson).

Lesson 6: Give your students more than what others give. Never ridicule them. Make the teaching simple by giving examples, do not complicate further. For postgraduates, skills have to be given more importance than theory because knowledge of theory can be acquired from many books. The most important contribution that a teacher can make to the juniors' training is to convert their knowledge to wisdom.

Dr Santhosh Pai's constant encouragement during this period prompted me to write a book. He told me to write a simple, user-friendly book. I did not take it seriously until one Malaysian student handed over my class notes nicely compiled to me and said,'Sir, your notes are getting Xeroxed and sold. Why don't you write a book?'. I started thinking about writing the book. When so many books were available, why write another one? By this time, I had completed 10 years of my service as a teacher and started realising their difficulty in going through bigger books such as Bailey and Love. Most of us have read Bailey and Love for surgery. It was called as Bible of surgery. However, look at the title of the book–it is 'A short practice of surgery'. I even interacted

with students from Leicester university, UK and asked them about Bailey and Love. The answer they gave me was that they do not read that book during UG days. I started editing my own notes, referred a few books for additional information to compile and added clinical discussion as symptoms and signs in the book while discussing clinical features. It took almost 4 years for completion of the first edition. Prof. Santhosh Pai named this book 'Manipal Manual of Surgery'. Thus, the first edition of Manipal Manual of Surgery was released on December 28th 1999, at Madurai ASICON by then President of ASI Dr. H.S. Bhanushali. CBS publishers, New Delhi, the publishers of my book were kind enough to arrange the books for release. Now book has seen 5 editions. Between 1997 to 2001, I worked with Prof. M. G. Shenoy, a great teacher par excellence who dedicated his life to teaching and patient care. He was very sincere to his patients, dedicated to students, well-updated and down to earth person who never wanted any publicity. Not only did I learn fine skills and wisdom in managing patients from him but also his dedication towards teaching. He encouraged me in every aspect of learning for an assistant. (lesson 7)

Fig. 6: 1st edition of MMS released by the President of ASI Dr Bhanushali on December 28th 1999 at Madurai.

FIG 7 : 5th edition is released by ASI President Dr Aravind Kumar in ASICON Bhubhaneshwar2019

Lesson 7: You need to have some innovative ideas in every aspect of life. What is called'Out of the box'… Think differently. You need to have vision for a particular job but you need passion to complete the job. Very often, it is 1 % inspiration but 99% perspiration, more so in writing a book.

The year 2001 onwards, I was made Chief of a Surgical unit. My clinical work and teaching continued. Were there any changes? The students were now getting many resource materials with the advanced technology of digital world - Google search, Pubmed, many books ase- prints, cell phones. However, students get confused as what to read because of several competitive books. Every book would add something that is not there in other books. Within 1 hour of the clinical teaching, the students have to learn maximum. With several subjects

to learn, they lack sufficient time to read all books completely. So, a teacher's duty is to read several books, collect relevant information, put them together and then take the clinics or theory class. This will reduce the burden on students of referring many books because even today it is not clear to them which books to read. This is the exact reason why students would like to attend your classes or clinics because you give them what they would have taken 3 hours to search. (Lesson 8)

Lesson 8: When you deliver your theory lecture or discuss clinical problems, make use of your knowledge and apply to clinics or to the lecture. Adding your experience to your lessons will keep you at least one step above the others.

In a medical college, one need not tell what to teach UG or PG students. There are ample opportunities everywhere. In the wards, you can teach bedside clinics, bedside procedures and bedside manners. I insisted that every student must come and talk to the patient the next day when they come for clinics. Example: A patient with hernia has been discussed in the wards and then undergoes hernioplasty in the operation theatre.They must watch the procedure and follow up the patient in the postoperative ward the next day and till he is discharged. I make students to see the specimen removed, cut it as and when required, open colonic specimen of abdomino-perineal resection, show them margins etc. Students will definitely appreciate you (Lesson 9).

Lesson 9: Involve students in patient management – not just for discussion but also in the follow up. They will like it. Students feel you have concern for them and have not conducted the case discussion only because you had to.

Soft skills are not taught to students including communication skills. MCI has instructed AETCom – Attitude, Ethics, Communication skills from the batch 2019. However, all our teachers had taught us these moral values indirectly or directly without using the word AETcom. Insisting that the students must come on time, with proper dress code as suggested by the college, including wearing proper shoes, being gentle during examination of the patient, maintaining privacy and many such soft skills. However, it was true that no specific rules existed then such as Consumer Protection Act and such. Times have changed now and we should change with the times.

Today students have to be told not just how to examine but details about undressing of the patient, what has to be examined and why must it be examined. They must also know what surgery, what are the possible complications and more importantly, the financial condition of the patient.

Two examples shook me and I was taken back. A 19 year old boy came with recurrent malignant fibrous histiocytoma (MFH). I operated and they paid the hospital bill (20 years ago). I referred the patient for further treatment. The patient was then lost for follow up. About 4 years later, patient's mother came for treatment for

gall stones.When I asked her about her son, she cried and told me he was no more. He died after 1 year of the second surgery after radiotherapy and chemotherapy. Then she told me that for her son's treatment, she sold a very small piece of land that she possessed and got the treatment. Now, she had neither her son nor the land. She was selling flowers in front of temple and her husband was a manual labourer. 'None of the doctors told me about seriousness of the condition and how many years he may live. Every one told me it is cancer. If you were to tell me that it was an incurable condition after 2nd surgery, I would not have got further treatment', she said.

The second patient was a nurse who was operated after neoadjuvant chemotherapy for locally advanced breast cancer. She spent 23 lakhs rupees for her treatment and survived only for 24 months. After few years, her relative came and told me that they spent so much money with the hope of guarantee of life. If they knew about her actual condition, they would have used that money for their children's education. Around 75% of our patients are from villages and they are all below poverty line. Let students observe you how you communicate with the patient in the OPD, in the ward or in the postoperative ward (Lesson10).

Lesson 10: Communication skills cannot be taught just by books or by lectures but only by experience of interacting with many patients. One needs to know the financial, cultural background of a patient, particularly so, in Indian patients. Bedside is the best way to talk to patients, console them, empathise with them.

A teacher's duty is not just to take clinics and leave but also to show the students the various investigations obtained, the reports, their interpretation and analysis. These are psychomotor skills. Especially in the present day, images of CT scan are available in most of the hospitals online. It is the duty of the teacher to discuss and correlate the findings with investigations. Many simple procedures are performed on the wards such as introduction of nasogastric tube, obtaining IV access, cardiopulmonary resuscitation after cardiac arrest, nebulisation, colostomy bag application, urinary catheterisation etc. The irony today is that a fresh MBBS graduate may be full of theory knowledge but may not know how to administer insulin or nebulisation to his own parents /relatives….I have tried my level best at each stage of teaching to see that these have been taught to students. Observe an introduction of nasogastric tube causes, how much discomfort palpating abdomen causes, how much pain removal of urinary catheter causes and other problems (Lesson 11).

Lesson 11: Every attempt should be made by the teacher to educate students about clinical skills and show them ward procedures. Not only correlating signs and symptoms to the disease but students should also be able to interpret and correlate lab investigations to the findings in a given patient.

In the last 15 years, I started concentrating on young surgeons who join as senior resident after completion of MS degree. As a unit chief, my first duty was to make them comfortable in the unit. I give them adequate chances in the operation theatre, guide them when they go wrong, impress upon them the importance

of teaching and responsibility. I give them more responsibilities as a surgeon and teacher, but I was available as and when required. Slowly, I have observed that young surgeons pick up laparoscopic skills much faster than senior surgeons(mostly). I insist that they get laparoscopic training because I myself do not have advanced laparoscopic skills that can be taught to young surgeons. This will boost their confidence and may help them in cases of a medico-legal issue related to complications of surgery. Some want to continue in the institution and many want to go for higher studies or into private practice. I was able to identify at least a few such surgeons with good teaching potential. A few continued in Manipal and some others joined medical colleges elsewhere. I always tell that every surgeon at some stage of their career will have problems due to surgical complications. These are acceptable provided you have explained to the patient and you have taken informed consent etc. Not taking a class, asking the students to get out without valid reasons and ignoring them is not acceptable. I am happy that a few of my assistants have learnt how I organise the teaching in the morning when faced with multiple batches and multiple responsibilities (Lesson 11).

Lesson 12. A senior surgeon/professor's duty is to produce another teacher /surgeon who will deliver a lecture better than you or operate better than you and organise the work better than you. Prepare the next generation!

It is very difficult for a general surgeon to know everything about many super specialities such as oncology, urology, gastro-intestinal surgery etc. These are the challenges now. Attending conferences, presentations, publications, attending workshops –all these are integral part of our surgical career. It is our duty not only to attend conferences and be a faculty or moderator but also to encourage youngsters to make them realise the importance of each one of them. Workshop for skills development, conferences for knowledge enhancement, research to create new knowledge, publications to know the systematic way of writing an article. In the last 15 years, I was invited to attend several teaching programmes mainly in south Indian medical colleges. In every teaching programme, I learnt new concepts and newer explanations. I have the habit of noting down these points in a small note book. Knowledge should be shared, otherwise it gets buried. I gained hundreds of well-wishers who have contributed for my success. I have to mention here, four of the very senior well-wishers (above 70 years) who always encouraged me, gave me opportunities in all possible ways, appreciated my teaching and also contributed for my knowledge- They are Prof. Ashok Godhi from JNMC Belagavi, Karnataka, Prof. Dayananda Babu from Trivendrum and Dr P Rajan from Calicut (Lesson 13).

Lesson 13. There is so much to learn about your subject from your interaction with your colleagues, both juniors and seniors.

My prime book, Manipal Manual of Surgery was published by CBS Publishers and Distributors Private Limited, New Delhi. In addition to MMS, I also wrote a book for BDS students, which covers theory and clinics. I then compiled a 6-author book of instruments. As a consequence of attending several teaching clinical sessions, I could write the 4th book titled,'Manipal Manual of Clinical Methods'. I need to mention Mr S. K Jain, an excellent gentleman, more than a friend, good host and a good human being. From the time of first call he made in July 1997, (a trunk call) till today, we have maintained our trust and friendship. Success does not come just like that. A tree which has grown very tall is visible. It is tall because its roots have gone very deep which we cannot see. Writing books is not easy but it is not impossible. I know several top class surgeons operate 12-18 hours at times but they cannot write even a few papers for publications. Writing a book and rewriting for editions requires passion, tremendous patience, precious time. Precious refers to some prime time including the early morning hours when you are fresh and everything is calm and quiet. It often requires many sacrifices. All my books were proofread by my wife Dr Anitha Shenoy (Nileshwar) for all the editions. This, she did inspite of anesthesia department at Manipal being a very busy department. This can happen only with one important motto, i.e., do not waste your time. Time and tide wait for none. It gives immense satisfaction that my book is read well in our country as well as a few other countries. (Lesson 14).

Lesson 14. You need 3 qualities to write a book apart from knowledge. 1 Passion. 2. Patience. 3. Precious time.

In the institution, one climbs up the ladder to become Head of the department. I was handed over the Headship from Dr Sampath Kumar. I was able to channelize the undergraduate and postgraduate training programme with help of my 2 seniors, Dr Ananda Rao and Dr Sampath Kumar. My position as HOD also gave me an insight into the various natures of surgeons. This is not about surgical skills but about their temper, work culture, and many others. There is a beautiful shloka in Sanskrit – The crow is black and so is the Cuckoo. How do you know the difference? Wait for vasanthakaala (spring time) and you will know. I was later promoted as Associate Dean, Academics during which I participated in Board of Studies meetings, gave suggestions to the departments as per guidelines issued by MCI etc. In 2017, I returned back to the department as Professor of Surgery till I turned 60 years of age on May 31st 2020. I received a letter that I am superannuated and have been given two years of extension as Professor of Surgery. In the last few years I got involved in the academic activities of Association of surgeons of India(ASI) , thanks to Dr. Santhosh John Abraham who could give not only me but many other surgeons opportunity to actively participate in the academic activities of ASI.

Fig.8.Prof. Sampath Kumar handing over the charge as HOD to me and welcoming me as the Head of the dept.

Lesson 14. When an opportunity is given to you, you should grab it, whatever be the work - minor or major, easy or challenging but do it with honesty and integrity. Start on a plan and start working on that. You will be successful. Do it with passion.

Presently after attaining superannuation (May 31st, 2020), I am back in the department as Professor of Surgery, waiting for students to return and join the department safely in the Covid period. I hope to do whatever I can in the coming years to provide service to the patients and to rid of their sufferings.

But now you readers can give me the answer to 'where have I reached' and also give me suggestions on what else I can do to grow further… I felt I have reached somewhere midway (Acharya) …. May be 50% or less of what our ancestors wrote about a teacher … still long way to go. I shall try my best, within my capacity to grow further…. That is my aim…..in the remaining years…I appreciate your comments and suggestions – Email to kallyarajgopalshenoy@gmail.com

Regards and best wishes.

Acknowledgements:

1. Almighty God who has defined my destiny
2. Parents who supported me and my family in the early days when the children were small.
3. Dr. Ramdas Pai, Chancellor, Manipal Academy of Higher Education, Mrs. Vasanthi Pai who gave me a PG seat (1983-1986) on merit basis at KMC Mangalore and a job at KMC, Manipal on December 1st, 1986. I am still continuing in a single institution without any changes, which speaks of how the faculty are being looked after .
4. Dr. Ranjan Pai, CEO and MD of the Manipal Education and Medical Group (MEMG).
5. Dr. Anitha Shenoy, my wife who has edited all the books - word by word with utmost dedication and devotion
6. CBS publishers and distributors who popularized the book all over India and other countries.
7. My vast group of friends and well wishers from surgical fraternity from all over country.

Guideline Series

The Process of Guidelines and Position Statement Formation under AMASI was envisioned in four phases:

Phase I: An expert reviews available evidence on each topic and suggests guidelines/position statement.

Phase II: The suggested guidelines/position statements are presented before a panel of experts who then critically evaluate them and suggest any amendments, if needed.

Phase III: The amended guidelines/position statements are presented before the members of AMASI through the newsletter and comments are invited, based on available evidence in published literature.

Phase IV: Once all the comments are analysed critically in light of the evidence submitted, any changes, if required are made and the final guidelines/position statements are released.

What follows is the phase 3 in the Guidelines and Position Statement Process of AMASI.

The AMASI members are requested to carefully go through them and if required, any changes can be suggest along with the evidence supporting such changes. Your suggestions along with the relevant references can be emailed to amasiguidelines@gmail.com

LAPAROSCOPIC CHOLECYSTECTOMY

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Introduction:

Laparoscopic cholecystectomy (LC) can be now considered the Gold standard, in both, the acute & elective, settings. This is an outcome of an exponential growth of knowledge, skill and technology in the field of minimal access surgery. Other notable guidelines on this topic were also given by different surgical societies, viz., EAES(1995), SAGES (2010), Italian (2012-14).

Indications:

The most common indication for LC is symptomatic gallstone disease.

Asymptomatic Gall stones

A Cochrane Review in 2007 found no evidence to either recommend or refuse surgery to patients with asymptomatic gallstones (No RCT comparing Lap Chole vs No Lap Chole). However, another meta-analysis by Duncan and Riall (2012) suggested that prophylactic LC for asymptomatic gallstone patients is not recommended.

Micro Calculi/Sludge:

This may cause migration pancreatitis, as the gall bladder motility is preserved. In absence of any other overt cause for recurrent pancreatitis, LC may be indicated in such patients.
Level of Evidence 4

Porcelain Gall Bladder:

There is a weak association of the clinical entity known as ‘porcelain gall bladder’ with gallbladder cancer (0 – 12 %). There may be a case of increased risk of malignancy in diffuse Intramural vs selective mucosal calcification, dictating the timing of surgery.
Level of Evidence 4

Risk of Gall Bladder Cancer

In certain high risk population, especially people residing in areas or belonging to ethnicities with higher prevalence of gallbladder cancer, there is an ongoing debate on whether prophylactice LC should be offered to obviate the risk of gallbladder cancer, which has generally a poor prognosis. However, currently there is no evidence to support indication of prophylactic LC.
Level of Evidence 3

Diabetics:

Similarly, there is not sufficient evidence to recomment prophylactic LC in type II diabetes mellitus.
Level of Evidence 5

Transplant Patients

In contrast, there is some evidence to support the use of prophylactic LC is asymptomatic gallstone disease in patients undergoing Cardiac Transplantation. **Level of Evidence 3**
However, for patients undergoing transplantation of kidney, pancreas or lung, expectant treatment is still the accepted recommendation.
Level of Evidence 3

Impact of co-morbidities in patients undergoing LC:

Obesity:

There is no increase in morbidity, mortality, and conversion rates when compared to the non obese population. **Level of Evidence 3**

Elderly:

LC is procedure of choice compared to open cholecystectomy (OC) due to less morbidity and post operative stay. However, conversion rates, CBD injury and hemorrhage are more in comparison with young patients. Early Elective Lap cholecystectomy is the recommendation. **Level of Evidence 3**

Pregnancy:

LC is treatment of choice and can be safely performed in any trimester of pregnancy. Early elective surgery is recommended to prevent harm the fetus. **Level of Evidence 2**

Cirrhosis:

LC in Child-Pugh A or B is associated with less postoperative complications, shorter hospital stay, shorter operative time and faster resumption routine than OC. **Level of Evidence 1**
However, surgery should be avoided in Child-Pugh C.

Antibiotic prophylaxis:

Perioperative antibiotic prophylaxis is recommended in LC to prevent postoperative infectious complications and to reduce medical costs. Whether or not to use a prophylactic depends on the individual patient, and the consideration of the attending surgeon. **Level of Evidence 2**

LC in acute cholecystitis:

LC is acute cholecystitis is a safe procedure & treatment of choice, with faster recovery & shorter hospital stay. **Level of Evidence 2**
There is no increase in the incidence of BDI **Level of Evidence 3**
There is an increase in operative time when admitted and treated for more than 2-3 days before surgery. The cut-off delay, after which the outcome is significantly worse, is not yet defined. **Level of Evidence 4**

The triad of obesity, acute cholecystitis and previous upper abdominal surgery
leads to higher morbidity, longer operating time and higher conversion rate. **Level of Evidence 4**

Suspected concomitant choledocholithiasis:

MRCP & EUS are able to detect the presence of calculi and exclude malignancy as the cause of obstruction, with a sensitivity and specificity ≥90 %. **Level of Evidence 2**
There is no evidence for routine use of intra-operative cholangiograpy (IOC) during LC, to detect occult CBDS in low-risk patients. **Level of Evidence 1**
With the advent of advanced imaging systems using fluorescence, the role of ICG cholangiography is still to be defined.
Preoperative ERCP is recommended in patients with high clinical and biochemical probability of bile duct stones and is not recommended for those with a low probability. **Level of Evidence 3**

Technique of LC:

North American Technique : The operating surgeon stands on the left side of the patient.

European/French Technique: The operating surgeon stands between the legs of the patient.

Majority of the surgeons, especially in India, follow the North American Technique and all subsequent discussion is about this.

Standard 4 ports:

- 10 mm umbilical or supra-umbilical port – for the laparoscope.
- 10 mm epigastric port for the left hand working instruments.
- 5 mm right hypochondrium port for the right hand working instruments.
- 5 mm ports in the right flank for gallbladder retraction.

Various modifications:

- 3 port LC: The right flank port is eliminated. While it is technically feasible and safe, both for acute and chronic cholecystitis, it does not reduce the analgesia requirements nor is there significant difference in terms of operating time, success rate and postoperative hospital stay as compared to standard LC **(Level of Evidence 1)**
- Mini-lap cholecystectomy: Using 5 mm scope and specialized thinner instruments, the remaining ports can be reduced to 2-3mm sizes. However, the cystic duct and artery have to be tied as the clip applicator is 10 mm in size. Modified Mini-lap cholecystectomy is using one 10 mm port in the umbilicus/supra-umbilical region and one 5 mm port in epigastrium. The remaining two ports are 2-3 mm with appropriately sized instrument through them. The laparoscope is 5 mm sized. Cosmetically superior with less pain and greater comfort.

Critical View of Safety:

“No tubular structure in the Calot’s triangle shall be clipped or divided until two and only two such structures can be identified entering the gallbladder”

Demonstrating the critical view of safety is widely accepted as it has reduced the incidence of bile duct injury in LC. **(Level of Evidence 4)**

Occlusion of cystic duct and artery:

The standard practice is to apply three non absorbable metal clips on each, cystic duct and artery and cut between distal and middle clip. Avoid clips when duct diameter ≥ 5mm . Clips related complications are known ((**Level of Evidence 4)**

Absorbable vs Non Absorbable clips: Reduced inflammation is seen with non-absorbable clips. However, there is neither any demonstrable benefit nor harm **(Level of Evidence 1)**

Monopolar cautery without clipping cystic artery may be sufficient for controlling small (≤3mm vessels). However, there is concern for adequacy of hemostasis & lateral tissue damage **(Level of Evidence 3).** Ultracision is superior to monopolar cautery but at a much higher cost. **(Level of Evidence 1)**

Use of stapling devices or ultracision alone for closure and division of both cystic artery and duct are not considered as standard operating procedures.

Dissection of the gallbladder from the liver bed:

Both monopolar cautery and ultracision dissector can be used for this purpose. Ultracision may result in less time and less blood loss (Level of Evidence 3).

Specimen Extraction:

The gallbladder specimen should be removed from the trocar site that offers the path of least resistance, produces the least pain, prevents contamination and provides the best cosmesis. To facilitate the above, various maneuvers as outlined below may be tried:

1. Reduce the size of the specimen by cutting it up intracorporeally.
2. Exteriorisation of the specimen partly, opening it up and sucking the contents out.
3. Use of retrieval bags: Reduces the risk of contamination (Level of Evidence 3)
4. Exchange the existing cannula (change the 10 mm canula to 12 or 15 mm one)
5. Enlargement of the site of the incision at the port site (Level of Evidence 4).

Umbilical vs Epigastric port for removal of specimen:

- Umbillical port: less postoperative pain, requires change in the position of the surgeon as well as the telescope, more risks of port site infections and port site hernia. **(Level of Evidence 4)**
- Epigastric port: Port site bleeding, the port track is oblique and so difficulty in removal of specimen, less risk of port site hernia and infection **(Level of Evidence 4)**

Drainage of liver bed:

Routine placement of a drain tube is not recommended as:

- Increased wound infection, pain, nausea seen in drained patients as compared to those in which no drain has been placed. **(Level of Evidence 4)**
- Hospital Stay is increased **(Level of Evidence 2)**

Port site fascia closure:

The true incidence of port site hernia in LC is not known. For all laparoscopic surgeries, literature reports an incidence rate of 0.65% - 2.80%. All ports larger 10 mm in size and larger should have fascial closure done, preferably with a non-absorbable or a delayed-absorbable suture material. (Level of Evidence 1). There is a lower incidence of port site hernia at the epigastric port (Level of Evidence 4). 5-mm defects do not require fascial closure in adults (Level of Evidence 3b).

When not to proceed/abandon procedure/convert to open surgery:

Conversion to open surgery is not failure of laparoscopy but a testament to the wisdom of the surgeon.

Laparoscopic should be abandoned when the safety is endangered **(Level of Evidence 2b).**

Predictors of conversion to open surgery are: (**Level of Evidence 3)**

1. Male sex
2. Advanced age,
3. Acute and chronic cholecystitis,
4. Obesity,
5. Liver cirrhosis,
6. Previous upper abdominal surgery,
7. Situations demanding emergency cholecystectomy,
8. Bilioenteric fistula
9. Cystic duct stones.

The decision to convert is correlated with following factors: **(Level of Evidence 2a):**

- Access problems
- Abnormal or unusual anatomy subsequent to acute or chronic inflammation
- Bleeding or visceral injuries
- level of surgical expertise at disposal

Conclusion:

Laparoscopic cholecystectomy is one of the most commonly performed laparoscopic operation. It is essential that the surgeon is familiar with the necessary guidelines for the performance of a safe surgery. The aim of the surgery should not be to accomplish it laparoscopically but to accomplish cholecystectomy in a manner which is safe, and ensures the most rapid recovery with least pain and morbidity for the patient.

Writing a Scientific paper

Dr. Vikram Kate

Case report – How to write your manuscript?

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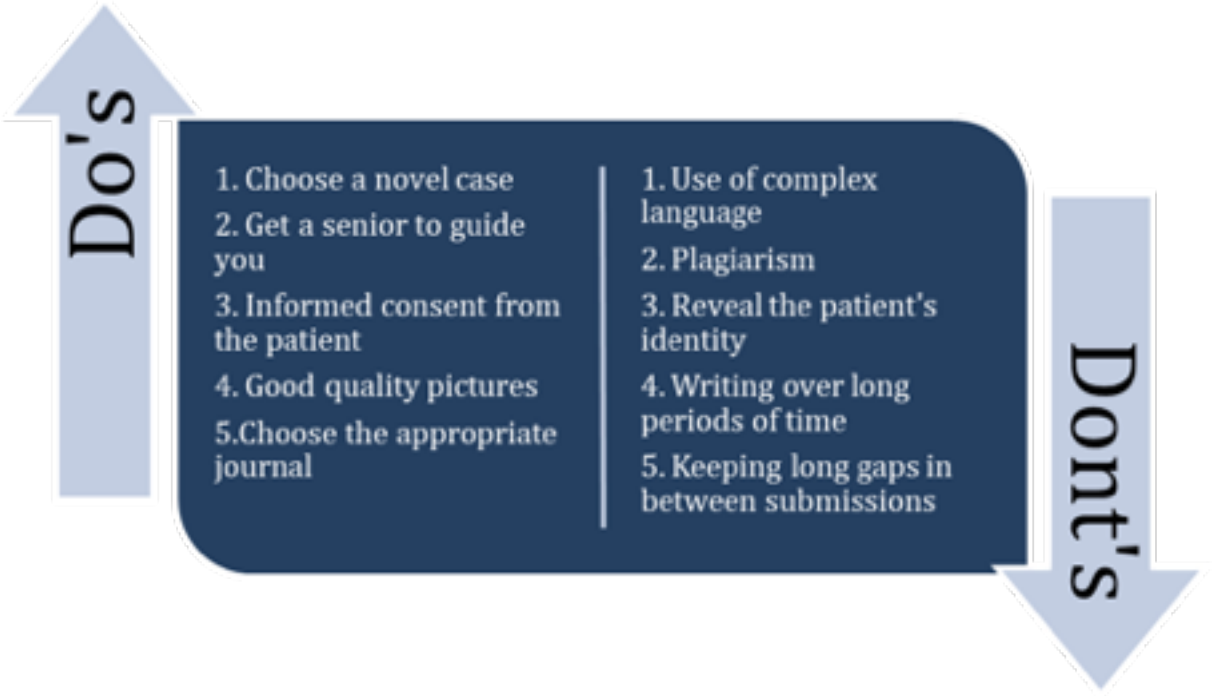
Introduction

Research is a goal-directed systematic process of inquiry focused on uncovering new knowledge to help understand phenomenon, answer questions, and address problems. Research is a critical part of any medical professional's career, be it a first-year undergraduate or the senior-most faculty. Reading and writing scientific papers is the way of communication with the vast medical fraternity. It is of special importance in the era of evidence-based medicine. Various job qualifications now include a specified number of good quality publications.

Case reports are the stepping-stone in the staircase of scientific writing. It is the easiest to write and understand. They are an effective way of sharing the experience in case of a rare diagnosis, unusual presentation of a disease, and/or a novel diagnostic or therapeutic approach to a patient. A case series is a cluster of similar cases, usually more than four1. The basic tools to write any scientific literature including a case report are the same. They include a keen interest, guidance from a senior faculty, a rough idea of research methodology and discipline. Some do's and don'ts of writing a case report are given below (Box 1).



Case selection

The search for a case that can be published as a case report should start from the first day of clinical postings and keep going on at all times. A case report can be written for the following:

A rare diagnosis

An unusual presentation of a common condition

Unusual events in the course of a common disease or a standard treatment

Co-existence of two or more unrelated conditions

A novel diagnostic and managementapproaches

Variations in anatomy.

Making a rare diagnosis may not be always possible; however, unusual presentation of common conditions is not uncommon and can be considered for writing the first few case reports. An unusual presentation of a common case such as cervical carcinoma was illustrated in a case report by Elamurugan et al2. Although carcinoma of the cervix is a quite common condition, its presentation with palmar cutaneous metastasis is exceedingly rare. Unusual events in the course of a common disease or a standard treatment can also be reported similar to a report on gastric outlet obstruction and intussusception following Frey's procedure in a patient with chronic pancreatitis3. In another case report by Prasanna et al4, a rare diagnosis of Rapunzel syndrome presenting with multiple small intestinal intussusceptions was described. Once the case fulfils one or more of the above requirements, the first thing to be done is to approach a faculty with good experience in research and publications. They will not only apprise you whether the case is rare and publishable but will also guide you on how to go about it.

The next step is to do a thorough literature search. Several online platforms such as PubMed, Medline, Ovid, Embase, and Google Scholar can be used to search for previously reported similar cases. This is important to establish the uniqueness of the report. If there are only a few similar reports and the recent reports on the topic are isolated cases, then that is indicative of the rarity. There is a high likelihood of acceptance of such cases in journals. On the other hand, if multiple case series are already published then a single case study on that topic will not add to the existing literature and hence need not be pursued for making a case report. Literature search also helps in understanding the case and the various therapeutic approaches used for it which can guide in the management of rare cases. When a novel approach with a better outcome is used then publishing that would add to its usefulness. An example of this is a report on the rare occurrence of the leiomyosarcoma of the breast and how to manage the same5.

Approach to writing a case report

Once a case is selected for reporting after a thorough literature search, the next step is to collect all the mandatory documents pertaining to that case. This includes:

Clinical findings

An elaborate note on present and past history and clinical examination findings, should be obtained. It should be precise and clear. It should be written in a simple language like a story in the same way a case is presented during ward rounds. Relevant positive and negative history should be included. Examination should be in a sequential manner including general followed by systemic examination with pertinent signs and symptoms, and special emphasis on positive findings.

Investigations

This should include all the investigations performed. They should be arranged in chronological order and the important findings should be recorded separately as well. It is of utmost importance to have high-resolution histopathology, intra-operative and radiological images of the case as and when necessary. They not only add to the attractiveness of the case report but are also a compulsory requirement in a lot of journals. A good quality clinical image has a fortuity to get published under ‘scientific image’; if in case the case report got rejected. A case report by Kumar SS et al on “cystic lymphangioma of the lesser sac in adult presenting with features of gastric outlet obstruction”beautifully demonstrates the use of intra-op, radiological as well as histopathology pictures in the same article6.

Treatment

The course of the patient in the hospital is written in-depth in accordance with the relevance. In cases with uncommon post-operative complications, it is imperative to write a day-to-day progress whereas in cases in which the emphasis is on the abnormal radiological or histopathological findings, a brief overview of the hospital stay should suffice. A case report by Sejal et al on massive gastric dilatation in a case of carcinoma stomach focuses on the need for index of suspicion of atypical presentation and gives the treatment of the condition in brief 7. No case discussion is complete without follow up of the patient. It is mandatory to mention the recent follow up3.

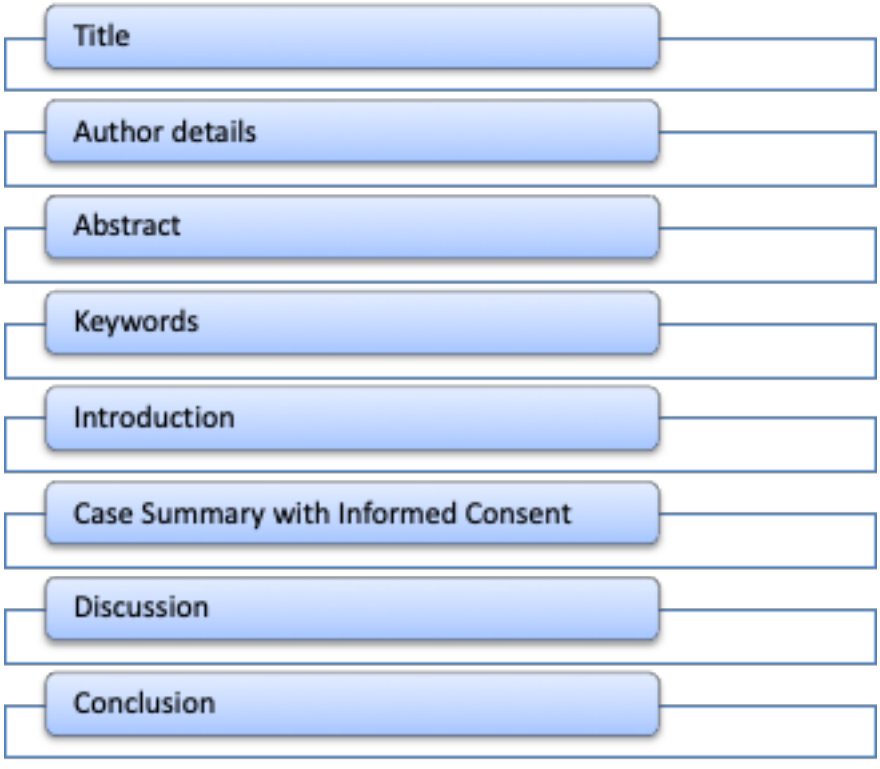
Informed Consent

An integral part of presenting a case and especially before sending it for publication is to take a written informed consent from the patient. Any pictures or details that can reveal the identity of the patient should be avoided. In case a patient succumbs to the disease, it should be specified when the consent was obtained. In the case of a minor or a patient of unsound mind, consent should be obtained from the parent/guardian.

The above-mentioned details should be included in the case summary section of the case report manuscript.

Structure of a case report in a journal

Once all the data is collected, it should be compiled under the following headings (Fig. 1):



Title and authors

A concise, crisp, and appealing title will grab the attention of the readers. It should not be too long or difficult to comprehend. 'Abdominoscrotal hydrocele: diagnosis by sonography', a case report by Sivam et al has a short but self-explanatory title8. The names, email ID's and qualifications of the authors should be checked before uploading.

Abstract

The only accessible component of an article in a paid journal is the abstract thus it should be attractive and well written. It could be structured with an introduction, case summary, and conclusion or more often a non-structured abstract for case reports, which is in the form of a paragraph. There is usually a word limit on abstracts and that should be considered. It is important that strict compliance for the word count for abstract is maintained, as the journal manuscript submission system will not accept the abstract beyond the mentioned limit.

Keywords

Commonly, 3-5 keywords are expected in a case report. They should be chosen wisely to make access to the article easy. As all words in the title of the articles are keyed, avoid using the words from the title.

Introduction

This is usually a brief overview of the condition that is under study. It starts with defining the condition, mentioning its incidence and the common features in short. The rarity of the case and its importance in the literature should be highlighted here.

Case summary

As mentioned above, this includes the history, clinical features, investigations, treatment, progress, and outcome in chronological order. This also includes the details of the figures cited.This is exactly like writing a discharge summary for a patient. This is the most important part of the report.

Discussion

It includes a brief summary of the present case along with a critical analysis of the report. Similar reports done in the past should be highlighted with the various similarities and differences in the current report versus the previous ones. Sometimes along with a case report, a review of literature is added which is mentioned usually in the title4. In these reports, the discussion includes a brief review of literature pertaining to that case report.

Conclusion

Last but not the least, this section again highlights the importance of the case report and the recommendations made through the same.

References

Each journal mentions the specifications on writing references. Although most of the journals follow the Vancouver style of referencing, it is better to confirm it. The in-text citation of the references can be either in superscript or parenthesis. It should be made sure that the references are correctly cited and in the same sequence as they appear. The number of references should not exceed the number mentioned in the instructions to the author.

Supporting Images

A case report must be documented with evidence in the form of supporting images. The high-quality images are usually uploaded separately with labels such as ‘fig. 1, fig.2 and so on’. They should also be arranged in the sequence as they appear in the report. It is also important to mention the legends for figures in the end of the article following references. The usual formats to upload images are PNG, JPEG,TIFF etc. However, the type of images accepted in a particular journal should be clarified from the instructions to the authors.

Revising and editing

Just writing the article is not enough. Before submitting to a journal for publication, the manuscript should be read by all the authors multiple times to correct any grammatical or other mistakes in the content

Selecting a journal for publication

The final and the most important step after writing a case report is to get it published. Few important things should be kept in mind before deciding on a journal. It should be a journal indexed in a standard search engine preferably with a high citation factor. The instructions for the authors part should be read thoroughly and the crucial points should be noted down. Non-adherence to the specific instructions can lead to immediate rejection of the report and hence should be strictly avoided. There is usually a word limit of around 1500-2000 for case reports which varies between various journals. A limit on the number of authors usually restricts the journals available for publication of a case report especially because of the contribution from multiple departments. Either a journal allowing a higher number of authors should be chosen or some authors could be acknowledged instead of giving a co-author status, depending upon their contribution. Another important thing that requires attention is the article processing charge (APC). There are a few ways by which a journal gets paid, either they charge the authors APC and keep it open access, or it is free for publication but charges the readers, or the institution subscription to that journal will allow their employee and students to submit it for free. A few journals give concession in APC to authors from certain countries depending upon the economic status. The acceptance rate of case reports in a journal should also be looked into. It depends on the number of issues that are released in a year, the number of case reports per issue and the number of case reports they receive in a year. Taking all these factors into consideration, a suitable journal should be selected. One extra step that can be taken is to select more than one journal. After submitting to one, the instructions of the other one should be read, and the article modified accordingly. The review process usually takes at least a couple of months. This way the case report can be submitted to the next journal very soon in case it is rejected by the first one.

Rejection of a manuscript is common, and one should not be disappointed by it. Sometimes it may get accepted in a better placed journal. A case report ‘Abdominoscrotal hydrocele: diagnosis by sonography’is a good example of it8. Initially it was submitted as a case of abdominoscrotal hydrocele to a regional journal (not indexed) and was rejected. The report was then modified, the ultrasound findings were highlighted, and then it was submitted to the Journal of Clinical Ultrasound (Indexed in PubMed) in which it was published. Being such an unusual report, it was republished again in a non-English journal after obtaining permission from the authors and the primary journal9. This shows that one should not get disheartened if success is not achieved in the first go. Good quality hard work will always reap its rewards. Scientific writing is an art that can only be learned over time with practice. Proper guidance and an enthusiastic learner are the two key parameters for a good article.

The international consensus guidelines for reporting standards for individual case and case series such as Consensus Surgical CAse REport (SCARE) Guidelines and Consensus-based Clinical Case Reporting Guideline Development (CARE Guidelines) are available with a check list which can be used by the young scholar who is starting the scientific writing for case report10.

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Prashna India

Dr VK Kapoor, Professor of Surgical Gastroenterology at SGPGIMS Lucknow, a member of AMASI, has launched a FREE online education portal - Prashna India - where students/ surgeons can ask (post) their questions. The questions are answered by experts in respective topics/ areas and the answers are posted online.

In the last 5 years, more than 300 students/ surgeons from all parts of India have asked more than 700 questions which have been answered by more than 70 experts from India as well as abroad. These questions and answers are available on Prashna India website for free.

Prashna India also conducts live online case presentations/ discussions and open-house question-answer sessions called Ru-Ba-Ru. More than 25 such sessions have been conducted so far with a maximum of 44 students from 22 centers attending one such session. Audio recordings of these sessions are available on request. Videos of last two Ru-Ba-Ru sessions are available to view on Facebook site of Prashna India 29th January and 3rd February 2019.

Prashna India can be visited at http://prashna-india.weebly.com/

Hobby Corner

After a long and illustruous academic career, **Prof. Saibal Kumar Mukherjee,** is currently working as Principal and Professor of Surgery at Nilratan Sircar Medical College, Kolkata.

He has a passion for travelling, photography and listening to music. Of the three, we present here evidence of two of them – travelling and photography. May you wander long and far, Sir, and keep clicking those polaroid memories!

The Pindari Glacier

Faith & devotion know no species- At Amarkantak

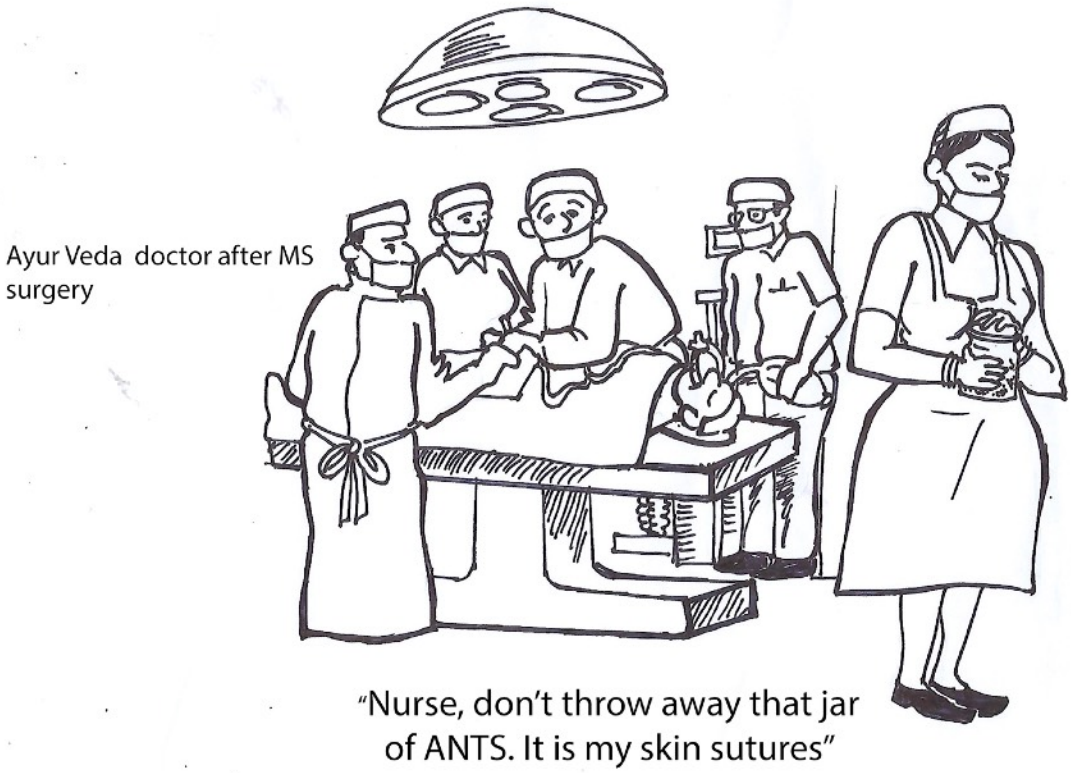
The imposing façade tells of the glorious past! - Jaisalmer

Memories are like reflections – fleeting and difficult to capture - Gadisar Lake, Jaisalmer

A tribal lady at Araku Valley

MAS Masti

Dr. Jobi Abraham



Past Events

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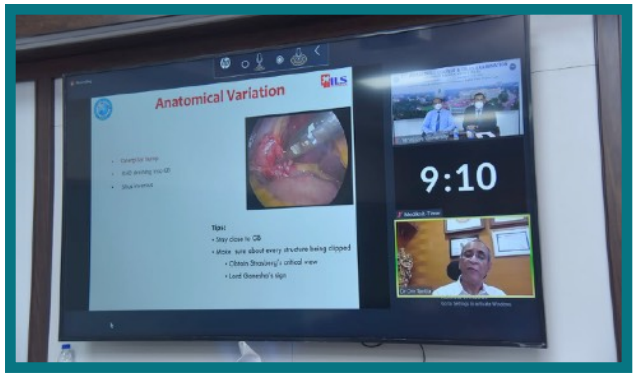
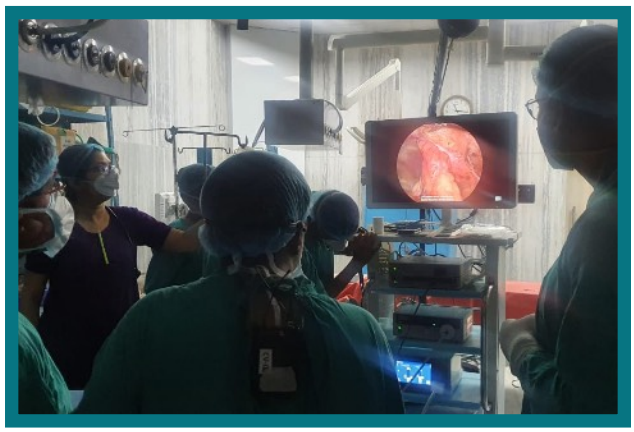
Event	Venue	Date	Organizer
AMASICON 2020	Virtual	20 - 22 November 2020	Dr.Kalpesh Jani Dr.R.Parathasarathi
East Zone Hernia Workshop & CME	Kolkata	20th - 21st January 2021	Dr.M.L.Saha





Upcoming Events

Event	Venue	Date	Organizer
e-FMAS Skill Course & Examination	Agra	28th - 30th January 2021	Dr. Himanshu Yadav
West Zone Hernia Workshop	Mumbai	28th January 2021	Dr.Roy Patankar
e-FMAS Skill Course & Examination	Imphal	11th -13th February 2021	Dr.Devendra Khwairakpam

AMASI

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