



AMASI

Newsletter



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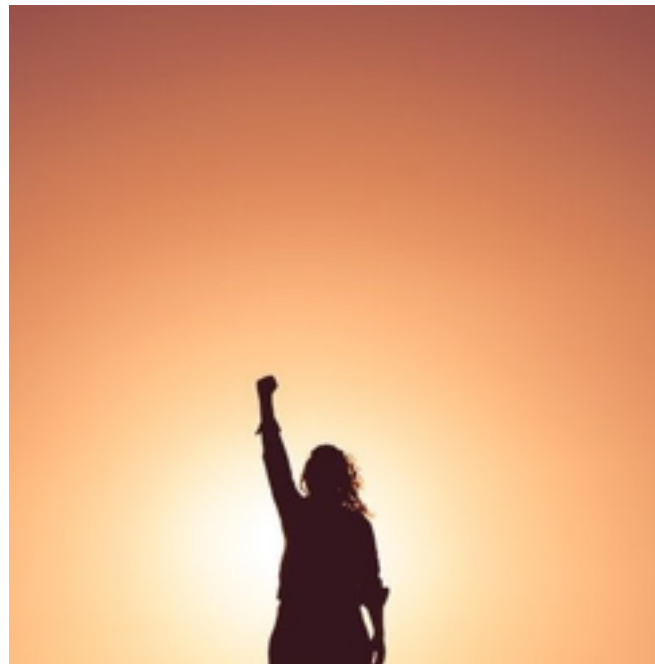
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It seems that we are beset by grim news from all sides. The summer days seem to be darkened by clouds of despair. Yet, there are stories percolating through, of undaunted spirit and perseverance. Healthcare personnel across India are fighting for the people, many a times, when all other avenues appear to have given up. Pharma companies have ramped up the production of life-saving drugs, the pace of vaccination has rocketed, industries have given up their own production targets to divert the much-needed oxygen to the healthcare sector.

Two poems spring to mind, as I ponder on the current situation. One by the African-American civil right activist Maya Angelou, born to poor black parents, sexually abused as a child, but rising to a position of eminence and influence in American arts and literature. Here I present some excerpts from her poem 'And still I rise':

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"Did you want to see me broken?

Bowed head and lowered eyes?

Shoulders falling down like teardrops,

Weakened by my soulful cries?

You may write me down in history

With your bitter, twisted lies,

You may trod me in the very dirt

But still, like dust, I'll rise.

.....

Out of the huts of history's shame

I rise

Up from a past that's rooted in pain

I rise

I'm a black ocean, leaping and wide,

Welling and swelling I bear in the tide.

Leaving behind nights of terror and fear

I rise

Into a daybreak that's wondrously clear

I rise

Bringing the gifts that my ancestors gave,

I am the dream and the hope of the slave.

I rise

I rise

I rise."

As images pour in of our brethren in PPE kits, working to the point of utter exhaustion, soaked in their own sweat, sleeping in snatches, resting whenever they get the time, leaving their loved ones at home without bothering of what may happen to themselves, one cannot feel that Sh. Harivanshray Bachhan wrote his classic "Agneepath" for them:

तू न थकेगा कभी,
 तू न रुकेगा कभी,
 तू न मुड़ेगा कभी,
 कर शपथ, कर शपथ, कर शपथ,
 अग्निपथ अग्निपथ अग्निपथ।

यह महान दृश्य है,
 चल रहा मनुष्य है,
 अश्रु श्वेद रक्त से,
 लथपथ लथपथ लथपथ,
 अग्निपथ अग्निपथ अग्निपथ।

As we hear of physicians and nurses working against all odds, in acute shortages of life-saving medications and oxygen, left to fend for themselves, no official representatives around to answer the public's vociferous demands for the shortages, fighting against seemingly insurmountable odds, what better way to end this piece than by the fine lines of Sh. Sohanlal Dwivedi:

न हाथ एक शस्त्र हो,
 न हाथ एक अस्त्र हो,
 न अन्न वीर वस्त्र हो,
 हटो नहीं, डरो नहीं,
 बढ़े चलो, बढ़े चलो

रहे समक्ष हिम-शिखर,
 तुम्हारा प्रण उठे निखर,
 भले ही जाए जन बिखर,
 रुको नहीं, झुको नहीं,
 बढ़े चलो, बढ़े चलो

.....

गगन उगलता आग हो,
 छिड़ा मरण का राग हो,
 लहू का अपने फाग हो,

अड़ो वहीँ, गड़ो वहीँ,
बढ़े चलो, बढ़े चलो
चलो नई मिसाल हो,
जलो नई मिसाल हो,
बढ़ो नया कमाल हो,
झुको नही, रुको नही,
बढ़े चलो, बढ़े चलो

WE WILL PREVAIL.

WE WILL OVERCOME.

Dr. Kalpesh Jani
Sr. Vice-President, AMASI.

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Guideline Series

AMASI 2015 Recommendation For Inguinal Hernia Treatment By Dr. Ramesh Ardhanari

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.

Plus the regular features like:

- ◆ MAS Masti
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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 amasiguideines@gmail.com



RECOMENDATION FOR INGUINAL HERNIA TREATMENT

Dr. Ramesh Ardhanari, MS, MCh(GE), FRCS(G)

Past President AMASI

Medical Director, Meenakshi Mission Hospital, Madurai

For the purpose of this presentation, the Oxford classification for levels of evidence and grades of recommendation is employed. It can be summarized as under:

Levels of evidence	Grades of recommendation
1A Systematic review of RCTs with consistent results from individual (homogenous) studies.	A Supported by systematic review and/or at least 2 RCTs of good quality
1B RCTs of good quality.	Level of evidence 1A, 1B
2A Systematic review of cohort or case-control studies with consistent results from individual (homogenous) studies.	B Supported by good cohort studies and/or case control studies
2B RCT of poorer quality or cohort or case-control studies.	Level of evidence 2A, 2B
	Level of evidence 2C, 3

Levels of evidence	Grades of recommendation
2C Outcome studies, descriptive studies. 3 Cohort or case-control studies of low quality. 4 Expert opinion, generally accepted treatments.	C Supported by case series, cohort studies of low quality and/or ‘outcomes’ research D Expert opinion, consensus committee Level of evidence 4

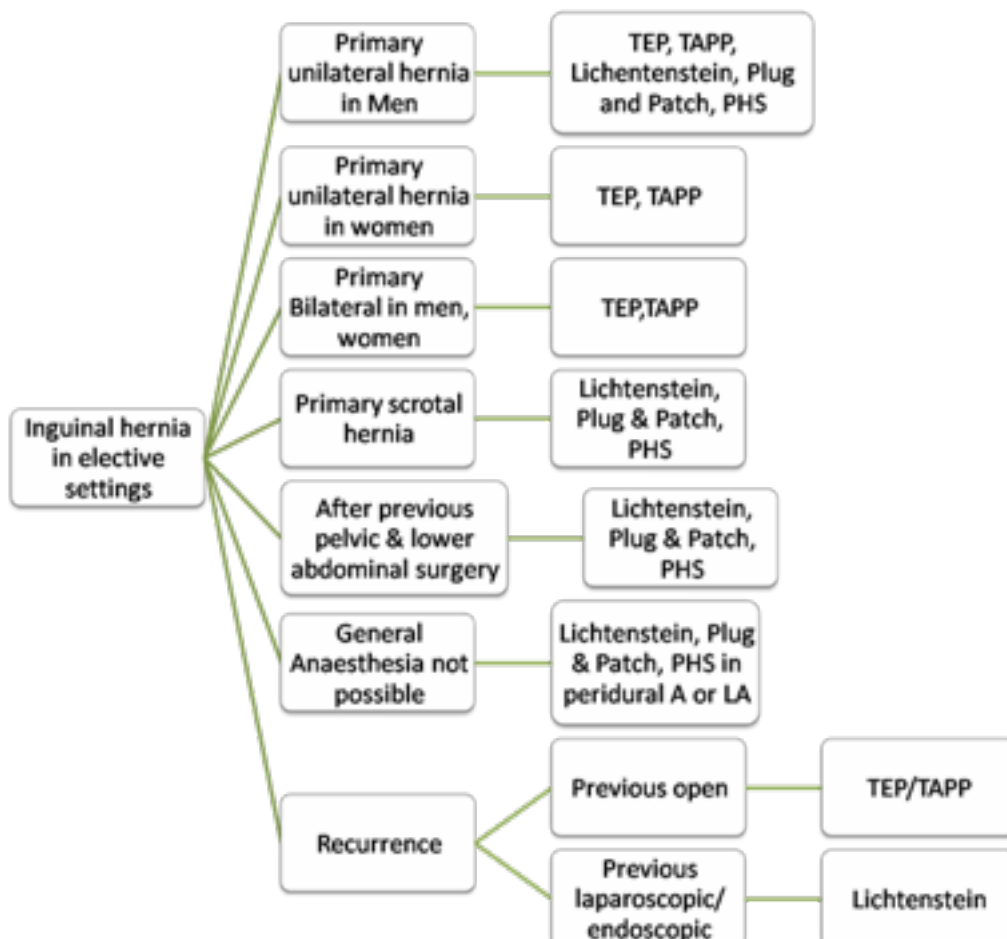
Diagnosis of inguinal hernia:

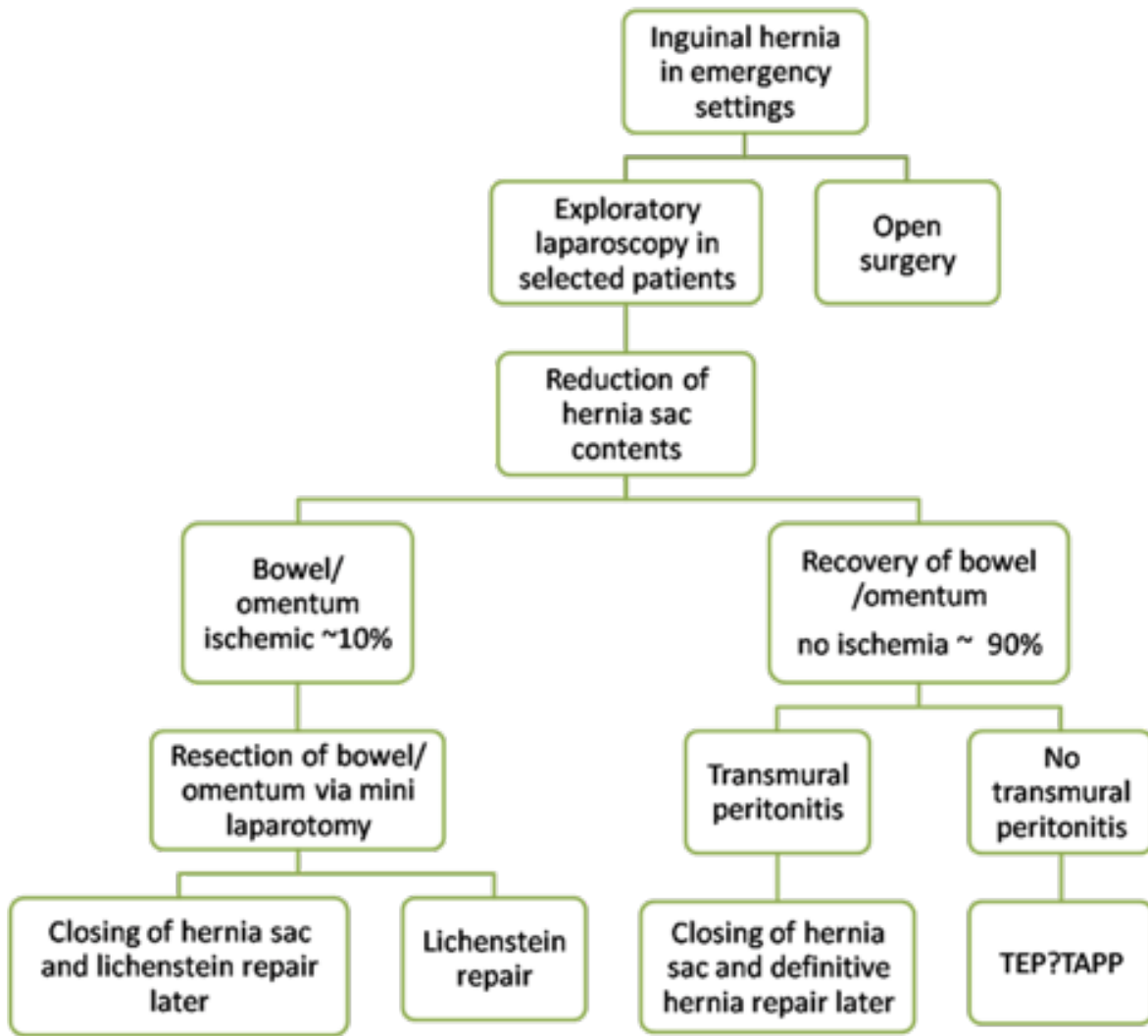
Inguinal hernia is a clinical diagnosis. Imaging is required in doubtful cases, complications, insurance claim purpose.

Clinical examination is accurate only in 75–89% of patients. The sensitivity of ultrasound is clearly higher than a mere physical examination. (Level 2B)

In case of clinical uncertainty diagnosing the hernia, an dynamic ultrasonography should be done. Dynamic MRI can be considered in doubtful cases. (Grade B).

Patient & Procedure Selection:





Uncomplicated hernia inguinal (unilateral/bilateral):

TAPP has a longer hospital stay compared to TEP, TAPP has a longer operation time compared to TEP. (Level 1A)

Regarding overall complication rate, there is no obvious difference between TAPP and TEP. (Level 3)

Potentially serious adverse events are rare after both TAPP and TEP. (Level 2A)

Unsuspected hernias on the contralateral side are easier to detect with TAPP. (Level 4)

Both techniques TAPP and TEP are effective methods of laparoscopic inguinal hernia repair.

(Grade A)

There is insufficient data to conclude about relative effectiveness of TAPP compared with TEP.

(Grade B)

Complex hernia:

TAPP and TEP are possible therapeutic options in scrotal hernia in experts hands. Operation time, complication rate, and frequency of recurrences are higher than in normal hernia repair. Sero-hematoma formation is the most frequent complication. Results will improve with gaining experience. Complete reduction of hernia sac is possible. (Level 3)

TAPP and TEP may be safely used when performed by surgeons with a higher level of experience in either technique. (Grade C)

Large complex hernias can be operated laparoscopically provided high level of expertise is available, TAPP is preferred method. Open surgery is usually recommended in such situations.

Inguinal hernia in female:

Women are at increased risk of having an occult synchronous femoral hernia. (Level 4)

When performing inguinal hernia repair in women, extra effort should be undertaken to reveal and treat occult synchronous femoral hernia. (Grade C)

We recommend laparoscopic hernia repair in females as it will reveal an occult femoral hernia on either side, if present.

Laparoscopic repair for incarcerated and strangulated inguinal hernia

Operation time is longer for complicated hernias than for uncomplicated hernia. Complication rate and recurrences are similar to uncomplicated cases. Advantage of laparoscopy is that bowel viability can be observed during the whole time of procedure. Frequency of bowel resection is less compared with open hernia surgery. (Level 3)

Reduction of hernia content or cutting the hernia ring if necessary for reduction may be safer when overlooking both peritoneal and preperitoneal space. (Level 4)

TAPP may be used for the repair of incarcerated or strangulated inguinal hernias, but the technique should be reserved for surgeons with extensive experience in the TAPP technique. (Grade C)

Compromised bowel that is encountered during TAPP repair of strangulated hernia may be resected after the completion of the TAPP repair (after allowing time for the bowel to declare its viability). The resection should be performed extracorporeally for intestine or may be performed intracorporeally for omentum or appendix. (Grade D)

Laparoscopic surgery can be performed for incarcerated/strangulated hernia if surgeon is highly expert but there should be low threshold to convert to open.

Preferred approach should be open hernia repair with or without mesh in such situations.

Recurrent inguinal hernia:

Both TAPP and TEP are advantageous in terms of defining anatomy and providing improved mechanical strength. Re-recurrence rate is equal or improved when compared with open techniques. (Level 1B)

Effectiveness of TAPP/TEP repair in recurrent hernia is equal compared with TAPP/TEP repair in primary hernia. (Level 3)

Laparoscopic surgery (TAPP/TEP) should be chosen in recurrent inguinal hernia after prior open anterior repair. (Grade A)

Recurrent hernias following previous open anterior repair should be preferably managed by laparoscopic method(TAPP/TEP)

Recurrent hernias following previous laparoscopic repair should be operated by open repair.

Occult synchronous hernia:

TAPP and TEP repair of inguinal hernia allow easy identification of the **occult ipsilateral femoral or obturator hernia**. TEP allows easy identification of concomitant contralateral direct hernias. TAPP allows easy identification of concomitant contralateral direct and indirect hernias. The laparoscopic approach obliterates these associated occult synchronous or potential hernias utilizing a single repair without any particular modification to the technique. (Level 4)

In inguinal hernia repair for diagnosis of occult ipsilateral hernia defects, a careful dissection of the whole pelvic floor should be done. (Grade B)

Ipsilateral occult femoral hernia can be repaired in both TEP and TAPP. TAPP allows for identification of contralateral occult hernia. This issue should be discussed with the patient preoperatively and if patient has given consent , it should be repaired simultaneously. Mesh repair of contralateral side should not be done in case of absence of hernia.

Mesh related issues:

A small mesh may be a risk factor for recurrence after laparoscopic inguinal hernia repair. Fixation does not compensate for inadequate mesh size. (Level 2A)

Lighter meshes with larger pores do not offer advantage in long term, but in initial convalescence period patient feels lesser discomfort. (Level 1A)

A mesh size of at least 10 x 15 cm is recommended. (Grade A)

Bigger mesh (i.e., 12 x 17 cm or greater) should be used for large hernias. (Grade D)

We recommend prolene mesh of size minimum 12x15 cm, covering all potential hernia sites(deep ring, superficial ring and femoral ring).

Mesh fixation versus non fixation:

Fixation and non-fixation of the mesh in TEP are associated with equal risk of postoperative pain or recurrence. (Level 1A)

Fibrin or n-butyl cyanoacrylate (NBCA) glue fixation is associated with less chronic pain than stapling. (Level 1B)

If TEP technique is used, non-fixation has to be considered in all types of inguinal hernias except large direct defects. (Grade A)

In case of TAPP repair non-fixation should be considered in types LI, II, and MI, II hernias (EHS classification). (Grade B)

For fixation, fibrin/NBCA glue should be considered to minimize the risk of acute postoperative pain.

General considerations:

- Antibiotics prophylaxis- although studies do not support use of prophylactic antibiotics, antibiotic can be given in perioperative period because we use reusable trocars.
- Thromboprophylaxis- not recommended except in patients with risk factors. Early mobilization and return to activities should be encouraged.
- Perioperative catheter drainage of urinary bladder- although not supported by strong evidence, perioperative urinary bladder drainage is worth considering to avoid risk of bladder injury.

Acknowledgements:

This manuscript would not have been possible without the hard work of Dr. Ram Rakshpal (then FNB Sr. Resident) and Dr. N.Mohan, Sr.Consultant GI Surgery, MMHRC.

Writing a Scientific paper



Dr. Vikram Kate

Retrospective Case Series: How to write your manuscript?

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1. Introduction: Broadly speaking, studies can be divided into prospective and retrospective studies. The prospective includes intervention studies such as randomised or cohort studies whereas retrospective studies include case series and other types which are primarily observational studies. These retrospective observational studies can be further divided into analytical or descriptive based on the inclusion of controls in the group. Mostly the retrospective case series are descriptive type of studies.

1.1 Definition of a retrospective study: A retrospective study is the one, that uses information on existing data, documents, records, or specimens. In this type of study, the investigators conceive the study and begin identifying and enrolling subjects after outcomes have already occurred. (1) When the data is collected prospectively in time when the outcomes have already occurred, it is still classified under retrospective study. The term in these circumstances that is commonly used is “a retrospective study based on a prospectively collected data base”. The data base which are collected prospectively are maintained on day-to-day basis on the area of interest.

1.2 Types of retrospective studies:

- ❖ Case series (also known as “chart review”)
- ❖ Case control study
- ❖ Retrospective cohort study

2. Step by step procedure/ approach for planning a retrospective case series:

2.1 Formulate a research question

If the researcher wants to portray their experience about a particular procedure carried out at their centre, a well thought research question can be formulated so as to portray the information which is lacking in the literature on that particular procedure. If a centre is well known for carrying out the esophageal bypass for corrosive strictures, the research question can be “what are the long-term outcomes of esophageal bypass for corrosive stricture ?” or “how is the quality of life of patients undergoing esophageal bypass procedures for corrosive stricture ?”

2.2 Prepare a Study protocol

The research protocol must be prepared in advance and should include the following elements:

2.2.1 Objective: The objectives of the study and its primary end points (outcomes) should be elucidated clearly. For example, the aim of the study could be to chronicle the long-term results of esophageal bypass for corrosive strictures using a modified left colon esophagocoloplasty at a single centre over a period of 30 years. (2)

2.2.2. Variables: The protocol must lay down the list of variables or items that the author wishes to study.

2.2.3 Population: The attributes of the study population should be described clearly: age, gender, disease characteristics, diagnosis, treatment given, etc. For example, in this particular study by Ananthakrishnan et al, the study population comprised of all consecutive patients of both gender and any age, who underwent esophageal bypass for corrosive esophageal strictures at the authors’ institute, over a period of 30 years. (2)

2.2.4 Time frame: The protocol must mention a specific date, e.g., “This study will only collect information on patients that presented to our institute between 1977 to 2008.” (2) Conventionally in a retrospective series, the data that we utilise is most of the time the completely stored data so that with a large number of patients more authentic results can be derived. An additional advantage of using a complete data is that when a change in trend occurs say for the approach or therapy, it can be documented.

2.2.5 Statistics: A description of the statistical techniques that will be used to analyse the data must be mentioned. One may choose to include a statistician for this. Usually, a simple retrospective case series employs descriptive analysis.

3. Data collection

Data can be collected in multiple types of format which may include hard copy such as proforma or a data collection form and electronic copy such as online accounts- one drive and airtable and from a prospectively maintained data base. Aim should be to collect the most accurate information in the shortest possible time. Thus, the proforma must be clear and straightforward.

Data collection can be done either through conventional method of reviewing and abstracting data from patients' paper medical records manually from the Medical Records Department (MRD) or from the electronic notes in the Electronic Health Record (EHR) system of the hospital.

Manual collection from hard copies of patients' files involves going to the MRD, sifting through all the files from the proposed time period, taking out the files where the diagnosis matches, and entering the relevant details in the proforma. The procedure is similar for retrieving information from the EHR or any other electronic database, except that the patient files can be accessed from anywhere using a computer system, with authorized login credentials. This type of data retrieval (manual or electronic) depends on the preferred mode of data storage at the researchers' hospital.

3.1 Steps in data collection:

Important steps in data collection include: preparing a proforma, converting the information that is available in patients' records to data in proforma, entering that data in master-chart in an excel spreadsheet, and subsequently, analysing that data.

3.1.1 *Preparing a proforma*

Think about the study question, it's aims and objectives and jot down, what information you want from the records. Typically, a proforma will have data collection points under the headings of basic demographics, history and examination. For e.g., suppose we want to analyse the epidemiological pattern of burns patients in our hospital, we will need to know the age and gender of the patient (Demographics), the cause and mode of burns, time delay from burn injury to admission in the hospital (History), presence or absence of inhalational injury, facial burns, burns depth, total body surface area involvement (Examination), presence of any associated injuries and co-morbidities, microbiological profile (Investigation) and outcomes.(3) It is better to make the proforma as detailed as possible, so that we do not miss out on documenting any information from the records. Later on, we can always exclude data from final analysis if necessary.

3.1.2. *Collecting patient files*

In this step, the researcher needs to inform, usually via a formal letter, the supervisor of the Medical Records Department (for accessing medical paper records) or of the Hospital Information System (HIS) (for accessing electronic records) that they wish to conduct this particular study, and that they may be granted access to the patient records from, say year 2000 to 2021. In most cases, the supervisor will then assign a subordinate to provide the

necessary files. The researcher can go through the main diagnosis of the case on the first page and shortlist required files, while returning the remaining back to the MRD.

3.1.3 *Entering data from proforma into master chart and statistical analysis*

Once data is entered in proforma, the next step is entering it into the excel sheet under the same headings. It is important to note that entering data into the spreadsheet must be done meticulously, as even small typos and spelling mistakes can affect data analysis. Once all the information is entered, various statistical tests can be employed depending on the type of data.

4. How to convert the collected data into a tables and figures in the manuscript.

The data from the master chart is then converted into tables. The general idea and details of the tables can be made based on the outcomes of the study. Conventionally most of the journals accept 4-6 tables (with figures). Hence, it is necessary to plan the depiction of data accordingly. It is important to note that there should be minimal overlap of the information in the tables, figures and the text in the results. In a retrospective case series, the tables will include the general demographic details of the patients included and the specific details of the area of the study. The figures can depict the details of the particular procedure details when necessary. (2) An algorithmic approach can be developed on years of experience for a particular procedure which can be shown as a flow chart in a figure. For e.g. in our retrospective study on both acute and chronic injuries of the stomach, a flow diagram depicting the details of management of cases gave a good bird's eye view of the entire cohort. (4, 5)

5. Ethics committee and patient consent

For a retrospective study, including chart review, ethical approval is usually not required when the data collected is in an anonymous mode. However in a retrospective case series manuscripts photograph of the patients (de-identified) may be used and hence is always appropriate to take an ethical clearance. It is a good practice to obtain ethics committee approval if sensitive information like results of DNA analysis being studied. Indian Council of Medical Research (ICMR) 2017 guidelines state that studies that do not involve contacting patients are exempt from ethics review but investigator may still have to make an ethics committee submission, requesting for a waiver. (6)

A retrospective chart review records patients' data without taking their written permission. Thus, it is important that any information documented by the researcher must not identify the patient (for e.g., patient's name, hospital number, telephone number, address etc). Thus, ideally, a waiver of privacy authorization is also necessary before starting the study. The ethics committee should give a clear waiver on individual patient consent included in the retrospective case series as it may not be feasible in a large data base.

6. Structure of a retrospective case series in a journal:

A retrospective case series can be submitted under the heading of ‘Original Article’ in most journals. An accurate and complete report must adhere to the STROBE guidelines for observational studies. (7) The key components of STROBE guidelines are title and abstract, introduction, methods, results and discussion. A further elaboration on what each components key elements are as well described. The components of the manuscript has been depicted in Fig.1.

6.1 Cover page:

Cover page must carry the title of the article, a covering letter, the details of all the authors and their affiliations; acknowledgment(s) if any; mention the important details of the corresponding author such as address, phone numbers and email address. The word count, table and figure counts, and an author contribution table may be included as per journal’s preferences.

6.2 Title and Abstract:

Common terminology should be used to mention study design in a title of an article. For an original research article, the abstract must be divided into these sections: Background, Aims/Objectives, Methods, Results, Conclusion. It should be short, concise and informative. The abstract in particular should contain what was carried out and what was found. (7)

6.3 Keywords:

These are terms that capture the crux of the article. These words make the article searchable, thus earning more citations. It is therefore, crucial to have the most relevant keywords that will help other authors find your paper.

6.4 Introduction

All original articles must start with an Introduction, where, the author must elaborate on the specific objective of the article, and indicate why it is important. It presents the rationale and novelty to your study, gives a reason about why the study is being done, and introduces to the aims and objectives.

6.5 Materials and methods

Under this section, the author must describe the 1) study design, 2) setting, location, time frame and method of data collection, 3) eligibility criteria of participants and method of selection of cases, 4) variables studied, and 5) the statistical methods employed. Details of ethics committee approval and patient consent must also be mentioned under this heading. (7)

6.6 Results

Results can be structured by mentioning the participants characteristics, descriptive data of the study, data of outcome variable and the inferential data.(7) Important trends including

any sub-group analysis, must be presented clearly and logically. Negative results must also be mentioned in order to prevent any bias.

6.7 Discussion

The first paragraph of the discussion summarizes the key findings of the results. (7) Emphasize what is new, different or important in the results. One may compare and contrast the results from those of previous studies. Limit speculation, and also include a paragraph on the strengths and limitations of the study. End by adding what the results add to the current evidence, and how it may impact the clinical practice, health policy etc.

6.8 Conclusion

Conclusion should be consistent with the study objectives/ research question.

6.9 Other information:

Funding: The sources of funding is incorporated in the manuscript at required section as per the journal's instructions. It also describes the role of the funders to indicate conflict of interest.

6.10 References:

The style of references (Vancouver or Harvard style) for articles, book chapter or electronic sources varies from journal to journal and must be checked before writing. Attention must be given to accuracy, formatting, and consistency. (8)

6.11 Tables, graphs and figures:

Readers often read the tables, graphs and figures before they read the text. They make a manuscript more readable by removing numeric data from the text. Graphs are a good way to demonstrate percentages, patterns and timeline of events. (3) Under figures, all line diagrams must be drawn by hand as much as possible. For e.g., in our retrospective report describing a novel sternocleidomastoid muscle myo-cutaneous inlay flap for corrosive cricopharyngeal strictures, the novel techniques were all depicted using hand-drawn line diagrams. (9)

7. Selecting a journal for publication

This is the most important step. Small retrospective chart reviews often do not carry as much weightage as prospective studies, and hence good journals with very high impact factors may choose to publish it as a Brief Report or Study Letter instead of a full-fledged Original Article. On the other hand, chart reviews dealing with rare conditions, large sample size, long term follow up of few decades (for e.g., registry-based studies, especially in foreign countries) are a treasure trove of information and it is good to aim for a good journal with high impact factor for these studies. Important factors for consideration before submitting your work to a particular journal include: novelty of the work, categories of articles accepted by a particular journal, target audience of the journal, length restrictions, reputation of the journal, and time to publication.

8. Potential pitfalls and errors

Chart review is an easy and inexpensive method of producing an original research. While the records contain important clinical information, the method of abstracting information is not without pitfalls, and can give rise to bias in the results. Some of the possible sources of errors and ways to overcome them are outlined in an article such as what to do if the needed variables are not found in the records, the authors suggest that a pre study collection of data is necessary to find the variables that are available in the records.(10) These are best practice guidelines, and it may not always be possible to adhere to them, given the constraints of man-power and other resources.

The advantages and disadvantages are shown in Figure 2.

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Fig 1. Components of a manuscript in a retrospective case series

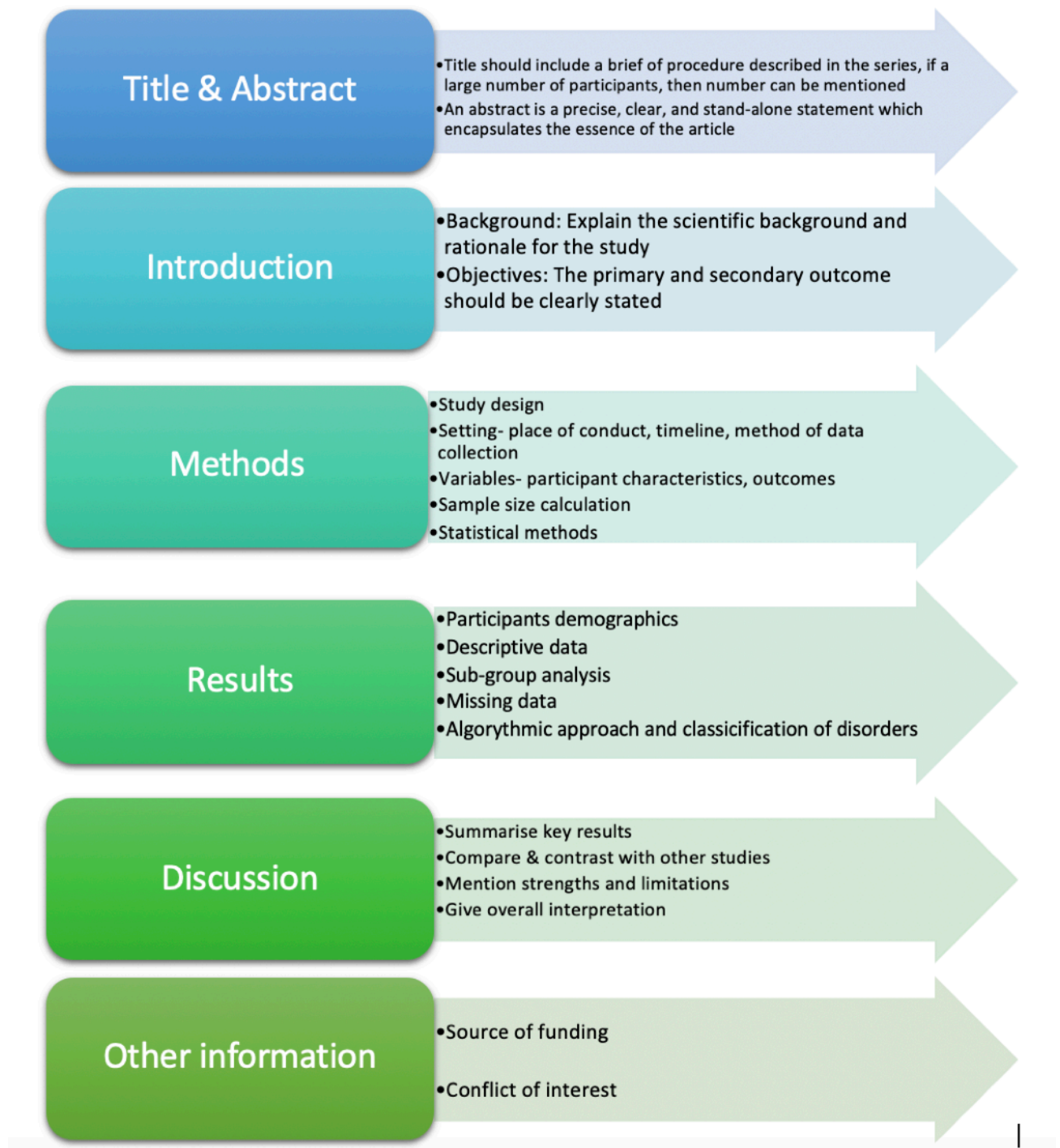
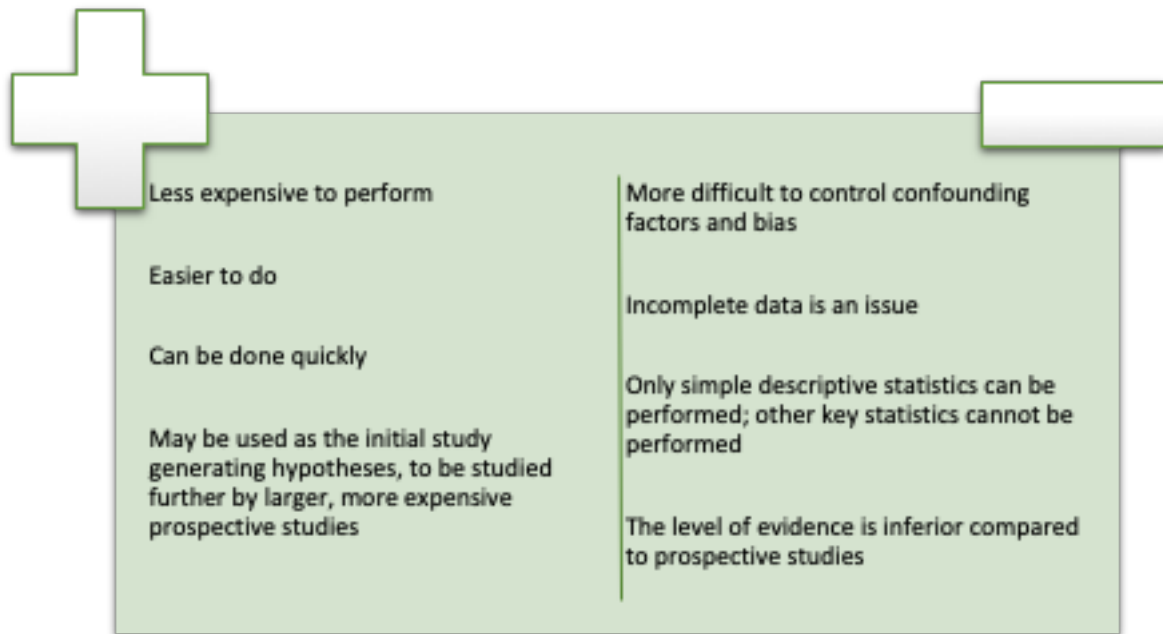
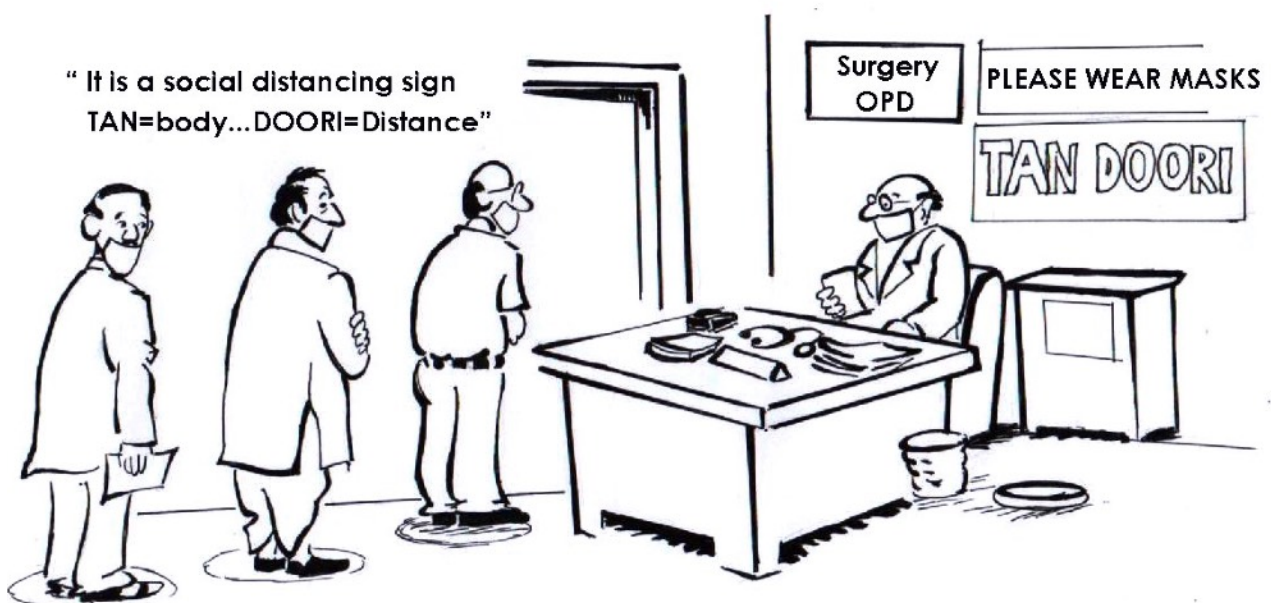


Fig 2. Advantages and disadvantages of retrospective case series



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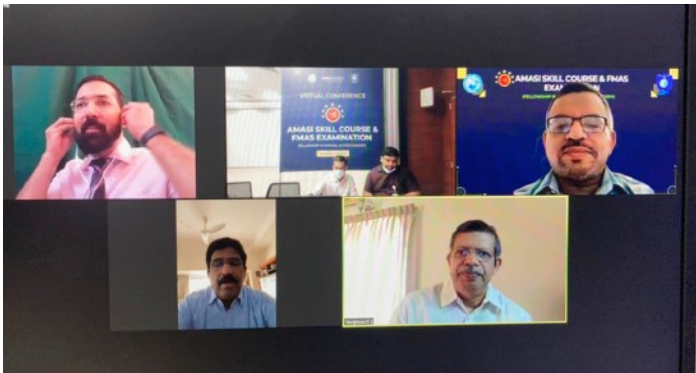
Dr. Jobi Abraham



Past Events

Event	Venue	Date	Organizer
East Zone Hernia Workshop	Kolkata	20-21st January 2021	Dr.Makhan Lal Saha
73rd e-FMAS Skill Course & Examination	Mumbai	28th January 2021	Dr. Himanshu Yadav
734th e-FMAS Skill Course & Examination	Imphal	11th -13th February 2021	Dr.Devendra Khwairakpam
AMASI Platinum Skill course e-FMAS Skill Course & Examination	Online	11-13 March 2021	Dr. Prakash K
A virtual CME on- "Surgery for Pancreatic diseases"	Online	2nd May 2021	Dr.Kalpesh Jani Dr.Samir Contractor
AMASI Live Workshop (Colorectal Surgery)	Online	17th April 2021	Dr. C Palanivelu
76th AMASI Skill course and FMAS Examination	Online	13-15 April 2021	Dr. Abhimanyu Basu
A virtual CME on- "Surgery for Pancreatic diseases"	Online	2nd May 2021	Dr.Kalpesh Jani Dr.Samir Contractor





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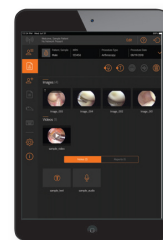
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Upcoming Events

Event	Venue	Date	Organizer
77th AMASI Skill course and FMAS Examination	Online	3-5 June 2021	Dr. Gajendra Bhati

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After a long and illustrious career, Prof. V K Kapoor has now retired from SGPGI. However, he continues to work with the same enthusiasm for the education and training of surgical gastroenterologists as well as general surgeons with an interest in GI surgery. He has kindly offered to share bestseller book for free to anybody wishing it. For your complimentary soft copy of 'Pearls in Operative Surgery', please email vkkapoor.india@gmail.com with PiOS in the subject of the email. Please share in your surgical groups.



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