GENERAL SURGERY

SSC 5C (ELECTIVE) Assessment part 1

Assessed by host supervisor/tutor

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Elective Subject: Surgery – general, laparoscopic and colorectal.

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Elective period: 6/5/2013- 7/6/2013

Objective set by school

1. What are the prevalent surgical conditions in East London? How do they differ from the UK and worldwide ?

2. How are surgical services organised and delivered? How does it differ from the rest of UK and worldwide ?

Objectives set by student

3. Describe the principles of laparoscopic surgery? What are the benefits and drawbacks of laparoscopic compared to laparotomy surgery?

4. Detail you reflections and experiences in this placement and what would you have done differently?

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I chose to complete my elective at the Royal London Hospital. Under the Dr Shafi Ahmed a general surgeon who specialises in colorectal and laparoscopic surgery.

As a general surgeon, they come across a wide range of surgical conditions such as upper gastrointestinal tract, lower gastrointestinal tract, hepatobillary and possibly the peripheral vascular system. A colorectal surgeon focuses on conditions pertaining to the lower GI tract of which there are many. The technique employed for this surgery is usually open surgery (laparotomy) or laparoscopic surgery. Laparoscopic surgery utilities modern high resolution cameras which are inserted in to the abdominal cavity through small incision made on the patients abdomen. The benefit of this method is that it helps to reduce the patient's length of stay in hospital and also the scars are more cosmetically acceptable to patients. Which method to use is a matter between the patient and doctor after careful consideration of the risk vs. benefits of both types. Often before any surgery is done, many investigations such as colonoscopy of flexible sigmoidoscopy are completed, allowing visualisation of the organ, biopsies to be taken and treatment to be given.

Lower GI conditions prevalent at the RLH (East London) include:

- Inflammatory bowel disease (Crohns disease and Ulcerative Colitis)
- Faecal incontinence
- Appendicitis
- Haemorrhoids, fistulas and fissures.
- Colon and Rectal cancer
- Polyps
- Rectal prolapse, intussusception and rectocele
- Abscess formation
- Diverticular disease
- Irritable bowel syndrome

Healthcare in UK is primarily under the NHS, whilst many choose to use private healthcare providers which provide quicker access to specialist care an intervention. In the NHS the care is subdivided into primary and secondary care. Primary care is generally the first point of contact for patients where they see their GP. If the GP feels it appropriatethey would refer to secondary care i.e to a specialist at the hospital. The other route is through the ambulance or A+E where patients are treated and directed to the appropriate place. The NHS system, is special because it is feel for all to use regardless of their income status.

Colorectal problems are picked up in many ways, GP's may recognise a need for referral due to the presenting complaints of patients such as change of bowel habit. Other ways of detecting abnormalities is the faecal occult blood screening, where the results are positive the patient is investigated further. So through these routes patients are referred to the surgeon. The patient is seen by the specialist at the hospital, the time between referral and being seen varies depending upon the urgency. Potential cancer cases are given high priority with a 2 week referral, whilst less urgent cases tend to be seen in around 6 weeks.

At the clinic itself a history and examination will be carried out, and the surgeon may decide to carry out further tests at the time such as protoscopy or for elective investigations such as colonoscopy. The management is of patients will initially ideally be using the conservative approach with patient education, lifestyle modifications such as optimising diet, weight loss and smoking cessation. The surgeon may decide to start new medical treatment or alter any pre-exisiting medications. If such therapy does not help to reduce or resolve the problem, then surgery is considered.

The multidisciplinary team plays a significant role in caring for patients with colorectal conditions. This team would include nurses, physiotherapists, radiologists, gastroenterologists, oncologists, pharmacists, dietician and a pain team. Once the patient is back in the community some of these members will play a part in the on-going care of the patient alongside their GP. There are some specific services run by the hospital for patients with chronic colorectal conditions including nurse led clinics for stoma education and care, also Rapid clinics for fresh rectal bleeding and Nurse led conservative management for function bowel disorders.

The first laparoscopic surgeries were completed in the 80's where an appendectomy and also later a cholecystectomy was performed using this method. Then in the early 90's the first laparoscopic training centre in the UK was established. Laparoscopic surgery has become a prominent method for abdominal surgery since then.

There are many benefits to laparoscopic surgery. As mentioned earlier it involves a few small incisions made to the abdomen which in turn results in reduced post-operative pain. The hospital and patients benefit from quicker recovery time which enables the patients to become mobile earlier and so patients are discharged quicker relative to laparotomy. The actual surgery in itself is costs more that than laparotomy but due to the patient spending less time in hospital overall cost of laparotomy.

Surgeons are able to see images of the contents of the abdomen on a large screen, giving a clear view. The negative aspect is that the image is 2D where as in laparotomy you will be able to see everything in 3D in its real dimensions. Tactile touch is also altered. Laparoscopic surgery can take longer due to having to identify structures and secure them before proceeding. To allow the abdomen contents to become more visible air is passed into it inflating it.

I enjoyed the surgical elective. Through clerking patients I learnt that to be diligent with every symptom of the patient as sometimes even though the patient may not look unwell they can be have cancer which has already metastasized. If I were to change aspects of my time, I feel I would have joined the juniors on call more often, as this would help me better prepare for being a junior doctor, and for being on-call.