INAUGURAL ISSUE

SUTRA

JULY 2025 | VOL - 01

THE NEWSLETTER OF THE INDIAN ASSOCIATION OF SURGICAL GASTROENTEROLOGY

NAMAKARANA

WHY SUTRA?

The Many Threads of "Sutra": A Sanskrit Word's Rich Tapestry

The Sanskrit word "Sutra" literally means "thread", "cord" or "string", forms a foundational concept in Indian intellectual and religious traditions, weaving altogether meanings far beyond its simple material origin. Its significance unfolds across multiple dimensions:

Literal and Practical

At its most basic, a sutra is a physical thread used for sewing, binding, or measuring – the essential tool holding disparate elements together. This tangible sense underpins its profound metaphorical extensions.

Philosophical and Scientific Code

Most famously "Sutra" refers to an extremely concise aphorism or rule. These are dense, formulaic statements designed to encapsulate vast areas of knowledge – philosophy, grammar *(like Panini's Ashtadhyayi)*, law, ritual mathematics or statecraft *(e.g., Kautilya's Arthashastra)*. Their brevity was mnemonic, aiding oral transmission. Think of them as "threads" upon which the pearls of complex knowledge were strung, requiring later commentary *(bhashya)* to unravel their full meaning.

Sacred Scripture

In religious contexts, particularly Buddhism and Hinduism, "Sutra" denotes a category of canonical scripture. Buddhist Sutra (Like the Lotus Sutra and the Heart Sutra) typically record discourses attributed to the Buddha, expounding doctrine and practice. Hindu Sutras (like Brahma Sutras, Yoga Sutras of Patanjali, or various Dharma Sutras) are often collections of those concise aphorisms systematizing theological, ritual, ethical, or meditative knowledge within specific schools.

Structural Principle

The concept of a "thread" implies connection and structure. Sutras serve as the core framework, the essential connecting threads, upon which larger bodies of commentary, explanation, and elaboration are built. They provide the skeletal structure holding the flesh of the tradition together.

Characteristic Brevity

The defining feature of a sutra text is the extreme conciseness. Authors aimed to express the maximum meaning in minimum words, often omitting connectives and grammatical particles. This compression made them potent but also necessitated expert interpretation.

In essence, "Sutra" embodies the act of binding knowledge. From the literal thread, it evolved into the metaphorical thread connecting ideas, the compressed code preserving wisdom, the foundational text structuring religious paths, and the principle of brevity demanding deep engagement.

It represents the elegant, efficient "threading together" of complex thought into a portable, enduring form – a testament to the power of language to weave intricate tapestries of meaning from the simplest of beginnings.

Suggested by
Dr. Gayatri Balachandran

IASG

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Dr. Subash Gupta
President
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MESSAGE FROM THE PRESIDENT

It gives me great pleasure to write this message for the newsletter of IASG. This newsletter will go a long way in fulfilling a long-standing wish of the Society and with Dr. Radhakrishna's academic credentials, I am sure this newsletter would be something to look out for. The discipline of Surgical Gastroenterology has grown rapidly over the years and is one of the most sought-after specialty for surgical training as this is a stepping stone for a career in Liver transplantation, Surgical Oncology, Upper GI Surgery, HPB Surgery, Minimally Invasive Surgery and Robotic Surgery.

Truly, we are in a period of rapid transition with requirements for advanced health care from our changing demography and push by the government to provide universal health care. Side by side, advances in surgical techniques, cancer therapeutics and treatment protocols happen regularly. Scholarships and trainings programs often announced quickly as the industry is keen for adoption of new techniques and instruments by the surgical fraternity. I am sure the newsletter will cover many of these developments.

Many new surgeons often begin their practice in isolation and may face difficulty with challenging cases and dilemmas in decision making. They would also like to report their interesting cases quickly and gain from experience of others. Whatever, we may have learnt from our training, they may not strictly be applicable in the new milieu where one gets positioned next. All surgeons begin by practicing what they had learnt and then realise that they need to tweak and adapt to the new milieu that they are now in. They then learn to innovate to overcome the challenges and finally, take on difficult cases in the consolidation phase and train other younger surgeons.

The newsletter will have sections on inspiring interviews of teachers, description of new surgical techniques, journal scans, job opportunities, developments in chemo and immunotherapy, ongoing multicentre trials, sections on critical care and anaesthesia and perspectives on health care.

It is also possible that the newsletter will in many ways serve as a Scientific journal of the society and hopefully our younger colleagues will share views on health care, career development and better patient management. It may also make our website more popular as it is quite likely that the newsletter will be a highlight of the website.

The newsletter will also look at how costs can be reduced, clear misunderstanding between patients and relatives, improve relationship between doctors and administrators, and bond better with nurses and technicians.

I am certain that Dr. P. Radhakrishna with his extensive contacts will invite articles from other societies engaged in similar work as us such as GI Oncology, IHPBA and Laparoscopic Societies of India.

I wish all the best and congratulate in advance for the phenomenal work that has been carried out in producing this newsletter and truly Dr. Radhakrishna has been met all these objectives and bring the Surgical gastroenterology fraternity together.

Dr.Sujoy Pal

Secretary
IASG

MESSAGE FROM THE SECRETARY

It gives us immense pleasure to present to you the inaugural edition of the IASG Newsletter — a new initiative that aims to serve as a vibrant platform for sharing knowledge, fostering collaboration, and celebrating the advancements in the dynamic field of Surgical Gastroenterology.

This quarterly newsletter is conceived as a space where the collective wisdom and experiences of our community can be shared, discussed, and preserved. In each edition, you will find insightful interviews with eminent surgeons and revered teachers, offering reflections on their journeys, surgical philosophies, and vision for the future.

We will also bring to your attention updates on key activities and developments in Surgical Gastroenterology, both from India and around the globe — including recent clinical advancements, noteworthy publications, surgical innovations, and journal scans of interest to our specialty. In addition, the newsletter will keep you informed about important conferences, meetings, and academic events, along with messages and announcements relevant to our membership.

As the field continues to evolve rapidly, it is vital for us to stay connected and informed. This newsletter aspires to be both a resource and a reflection of our vibrant professional community.

To get this project going I would like to personally thank the 6-membered IASG Newsletter team led by Dr P Radhakrishna. The members are Drs Magnus Mansard, Gayatri Balachandran, Deeksha Kapoor, , Shraddha Patkar and Nisha jain .

We invite you to engage with it actively — as readers, contributors, and critics — so we can continue to grow stronger together. Your feedback and suggestions will be invaluable in shaping future editions.

Dr.Patta Radhakrishna

Executive editor
"SUTRA"

MESSAGE FROM THE EXECUTIVE EDITOR

Most professional bodies in India either have a journal of their own or at least, a news letter being published periodically. A journal or a newsletter has become some sort of a tradition and we, from the Indian Association of Surgical Gastroenterology should not be far behind. The present team leading the Association had felt that it is high time we have a newsletter of our own and hence this effort. This will be an online journal, released every quarter to start with and see how it evolves. Unlike a purely scientific journal, this newsletter will be of a different nature focussing on things and events associated with GI surgeons and not pure surgical science itself.

The focus will be on innovations, publications and achievements from India. Eminent Indian GI surgeons will figure prominently in the newsletter and one maverick surgeon's interview will be published in every issue. Surgical philosophy, travelogue of a young surgeon, non-academic interests and a whole lot of pot-pourri will figure in the issue. Suggestions are welcome and please feel free to mail you opinions about the newsletter.

We have a bunch of young and energetic surgeons in the editorial team that includes Dr.Gayatri Balachandran, Dr.Deeksha Kapoor, Dr.Sharddha Patkar and Dr.Nisha Jain ably led by Dr.Magnus Jayaraj Mansard, a transplant surgeon from Chennai who will be the editor-in-chief. Please send your articles and photographs of important events taking place in your unit, hospital, town or city to the mail ID given in the newslatter.

The newsletter of IASG is titled 'Sutra' as suggested by Dr.Gayatri Balachandran and has many connotations that include a philosophy, a doctrine and a thread that binds everything and everyone. This 'thread' differentiates us, surgeons from everyone else in the medical profession. Please wish 'Sutra' all success.

Dr.Patta Radhakrishna
Director, GI and Minimal Access surgery
Malar-MGM Hospital, Chennai.
Executive Editor
" Sutra "

Dr.Magnus Jayaraj Mansard

Editor - in - cheif
"SUTRA"

MESSAGE FROM THE EDITOR-IN-CHEIF

Dear Colleagues,

It gives me great pleasure to introduce the inaugural issue of Sutra, the official newsletter of the Indian Association of Surgical Gastroenterology. This isn't a journal. It's not a bulletin. It's a stitched-together space—a knot of ideas, insights, stories, and surprises from the world of Surgical Gastroenterology in India and beyond. Sutra is our attempt to bind the clinical with the contemplative, the serious with the satirical, the technical with the human. We hope to create a space that not only informs, but also inspires and connects.

In our very first issue, we celebrate a golden landmark—the 50th anniversary of the Department of Surgical Gastroenterology at Trivandrum. It is a chapter of historical significance, and a reminder of how far the field has evolved.

We are privileged to feature insights from one of the founding members of IASG, who writes with nuance and clarity on the cultural context of surgical consent in India—an issue as ethical as it is practical.

From here, we leap forward to innovation—with a spotlight on a surgical robotic system made in India, a testament to the growing spirit of technological self-reliance in Indian surgery.

An engaging interview with a young but accomplished colleague offers perspective on the aspirations and realities of the next generation of surgical leaders. Our Travel Diary section follows the journey of a fellow during an international observership in Korea, offering reflections both professional and personal.

This issue also introduces WIGIL—Women in Gastrointestinal Surgery and Liver Transplantation—a group that is shaping new conversations around leadership, mentorship, and representation within our specialty.

We turn the lens inward as well, with an essay exploring the personality of the surgeon. But the scalpel isn't all we hold. One of us speaks of music—how learning the mandolin has made him a better surgeon. Another writes with humour and honesty about the peculiarities of our profession, somewhere between rounds and reality.

You'll also find a video vignette of a novel procedure, a clinical case that made even seasoned minds pause, a roundup of the latest in journals, and of course—a quiz for the brave.

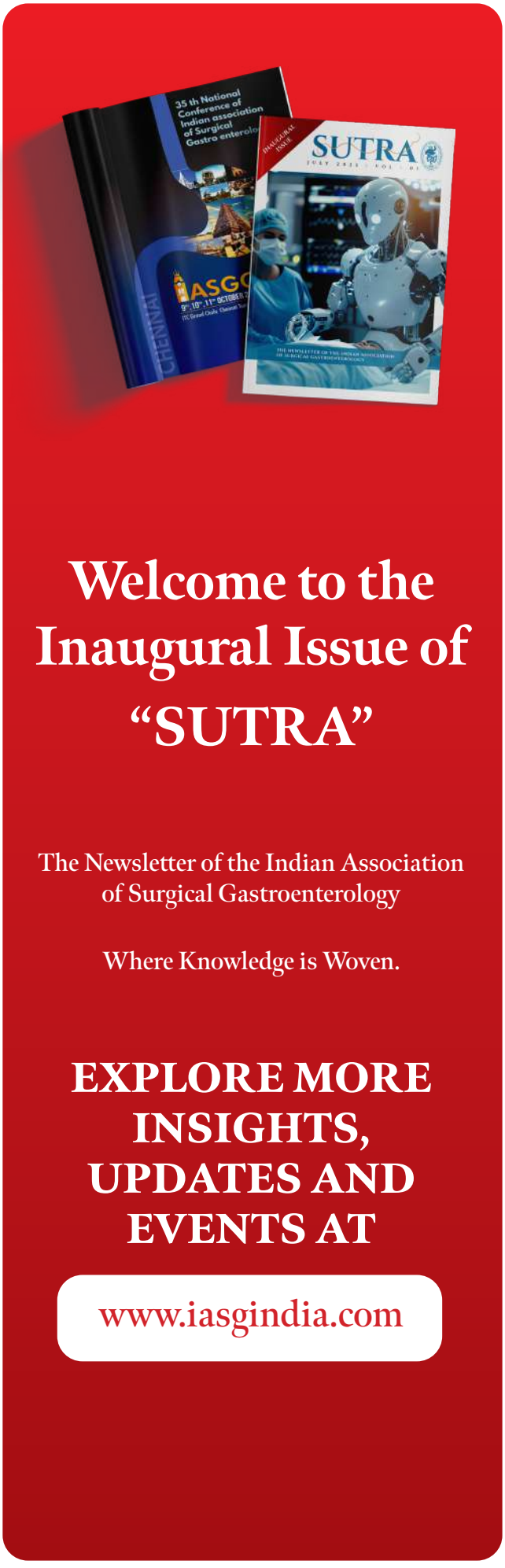
Academic rigour continues through journal reviews and a quiz, but Sutra also makes space for the less often heard, yet deeply meaningful voices. A surgeon shares how music—particularly the mandolin—has enriched his surgical practice. And in our opinion column, we look at the quirks and quiet truths of surgical life through a more humorous lens.

It is our hope that Sutra becomes more than

a newsletter. We envision it as a platform for dialogue, creativity, and shared purpose—a publication that reflects the evolving identity of the Indian surgical gastroenterologist.

We invite you to read, reflect, and most importantly, contribute. This is just the beginning.

Dr Magnus Jayaraj Mansard
Lead Liver Transplant Surgeon
GEM Hospital, Chennai
Editor-in-Chief
" Sutra "



Welcome to the Inaugural Issue of "SUTRA"

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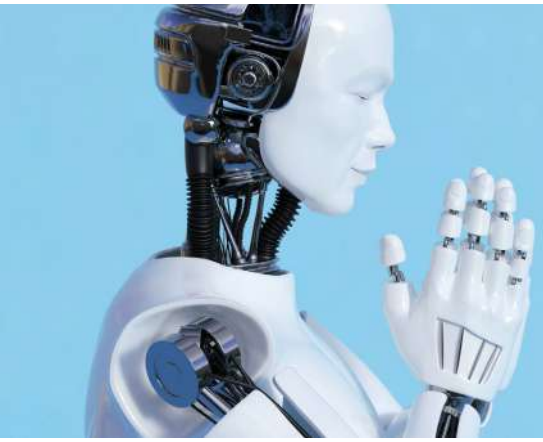


A SURGEON'S PRAYER TO GOD / MOTHER NATURE

Dear God / Mother Nature,

Confer my brain with intellect and intelligence to imbibe the science of Surgery,

Grant my mind, the wisdom to benefit my race,

Bless my hands for whatever may I perform with them, resurrect rather than disrupt,

Direct my intentions towards empathy and alleviation of suffering of all those alive, not be a cause of them,

Award me faithfulness, fearlessness and focus towards purpose,

Grant me the hustle to be thirsty for knowledge forever, as long as I perform,

Allocate me the elixir in bountiful measure, to be the panacea of sufferings of my brethren,

Accord me the sensibility to place pain and despondency of others above my own interests and ego,

And if at all I am punished to be the cause of sufferings to my brethren from my actions, may my intentions and competence never be under question,

Assign me success and victory in all battles that I engage in, sans the intoxication that universally consorts surreptitiously alongwith,

Also, the gift of profound calm of mind to face my failures, without they overwhelming my compassion, sensibility, logic and actions,

And after you have granted me this trove of lavish treasure,

Forget not also to grant me an impenetrable armour to ward away hubris and megalomania,

That escort the virtues you bequeath me!

Dr. Kanwal Jeet Singh
Principal Director & Senior Consultant
Gastrointestinal Surgeon
Livasa Chain of Hospitals, Amritsar

THE SURGICAL PERSONALITY

Myth, Mask or Evolving Mindset?

"A surgeon should be youthful... with a strong and steady hand... vision sharp and clear, and spirit undaunted... filled with pity, yet unmoved by cries... he does everything just as if the cries of pain cause him no emotion."

- Celsius, De Medecina Book VII

On June 17, an interesting topic was discussed on the monthly Women in GI surgery and Liver Transplant (WIGIL) webinar – the concept of an archetypal Surgical Personality. Most surgeons have, at some point, heard the remark "How typical of a surgeon!". But what does that even mean? Does it refer to that cantankerous but revered Surgery professor in medical college, or perhaps the unforgiving albeit brilliant senior resident during training. Tireless, domineering, unyielding, unemotional – they exude confidence and are unafraid to take the hard calls. As the adage goes - A surgeon – sometimes wrong, never in doubt.

Dr Sanjay Govil, Senior HPB and Liver Transplant surgeon from Bengaluru, dissected this myth of a Surgical Personality in an eloquent speech. He described the quintessential surgeon, embodied in the character of Sir Lancelot Spratt. "Burly, brash and bullish. He cuts first, ask questions later, because to cut is to cure, and the best cure is cold hard steel.... Good with his hands, but has no time to explain. Compassion and communication are for sissies."

Furthering the stereotype was the description he found of a typical female surgeon, "a cold, impersonal micromanaging shrew". Dr Govil discussed the origins and justification of this persona. Surgeons of yore needed to be of strong disposition, unaffected by screams from unanaesthetised patients. In a time when operations had to be performed swiftly and surely, there was no time to discuss, to collaborate, or even communicate. As French army surgeon Dr Henri de Mondeville wrote, 'to be a surgeon, you need to have a strong stomach and the ability to cut like an executioner'. Even as anesthesia and asepsis ushered in an era of humane pain-free surgery, this no-nonsense 'hero-warrior' aura of the surgeon persisted. Dr Govil acknowledged that while the cliche is not always representative of the tribe, there are some personality traits that surgeons do seem to share, which make them stand out from their physician counterparts. Studies suggest that surgeons demonstrate higher scores than physicians in the psychological domains of openness, agreeableness, and conscientiousness, as well as in neuroticism which tends to increase with age. Women surgeons had higher scores in extroversion and agreeableness. "... Maybe they just are nicer", he quipped!

The sheer demand and stress of surgical life can exact a mighty toll. Surgeons tend to jade themselves and remain emo-

tionally distant, as a self-preservation tactic. This 'compassion fatigue' can accelerate burnout. The surgeon's shell of narcissism and overconfidence often masks insecurity and hidden pain, especially after complications and adverse patient events. The very same qualities that make a "good surgeon" – passion, precision, and perfection- may in fact be the instruments of downfall as they blur into overwork, micromanagement, and exhaustion. Dr Govil spoke about the need to address this destructive culture and the need for effective coping mechanisms within the profession.

Robert Liston amputating the limb of an unanesthetised patient.

In the discussion that followed, an interesting point was raised. Are some perceived "negative" traits, (like being uncompromising and driven to excellence) truly flaws, or are they necessary to achieve optimal results in a field like ours where a minor error could make the difference between life and death? The surgeon, it was argued, needs to be an unrelenting perfectionist. After all, 'the scalpel does not cut well when it loses its edge'. While tantrums achieve nothing but to erode team morale, firmness and exacting standards are often essential in the interest of patient safety. The key is to communicate to the team that such exchanges are never personal and seek only to assure the best care for the patient. As Dr Supriya Sharma, Prof of GI surgery at SGPGIMS Lucknow, aptly noted, "You don't need to change too much about yourself, just be aware when you go wrong, and take the effort to make up for it."

"You don't need to change too much about yourself, just be aware when you go wrong, and take the effort to make up for it."

Another key point was how important personality types were in deciding on a career, especially for the newer generation of medical students. The consensus was that there is no such thing as a preordained personality suited to surgery, and that individual social skills, interpersonal style, and demeanour varied from person to person. Soft-spoken or assertive, the unifying trait, is the ability to rise to the occasion and take charge when the moment demands.

Dr.Sanjay Govil

As one audience member suggested, values necessary for success such as determination, tenacity, and hard work, are not unique to surgery; you need them to succeed in any field. Interestingly there is no shortage of the "surgical personality" among physicians either. Exactly how this behaviour became associated with, tolerated and even encouraged within surgery is a topic worthy of reflection.

A query posed by an MCh trainee sparked an honest exchange. Does being emotionally affected by a bad outcome make one less suitable for this profession? The audience strongly disagreed. They concluded that emotional sensitivity is not a weakness, rather it makes one a better doctor and human being. But it can have a profound impact on a surgeon's mental well-being, both men and women alike. Normalizing conversations around mental health is crucial, and having support systems – be it a spouse or a trusted friend– makes the struggle surmountable.

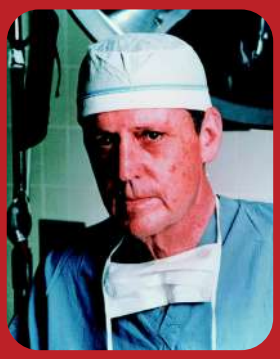
Surgery as a profession has changed dramatically, and the "captain of the ship" mentality has morphed into one of collaboration and cooperation. Tyranny and abuse have no place in the modern workplace. A slow but steady shift towards diversity is bringing in newer perspectives. Furthermore, patients today do not cower and hang onto our every word like dogma. They are astute, aware, and empowered. As

Dr Govil put it "You don't see Lancelot Spratt in the OT anymore. We have turned into physicians who can operate in the true sense of the phrase." As our role evolves, so must our mindset. While partly innate, one's persona is still heavily influenced by experience and conditioning. Hence, it can also be modified. Modern surgeons need to develop a culture of teamwork. As leaders, they must foster an environment of openness, where opinions (even contrasting ones) are welcomed. They must inspire rather than intimidate those with whom they work. Confidence, not arrogance; leadership, not dictatorship; lead with calm, not chaos - this must be the mantra in the OR's of today.

So fellow surgeons, we have a delicate operation to perform – carve away the toxic stereotype and retain the skill, guts and grit that define the best of our profession. It's a fine balance... are you ready for the change?

Dr Gayatri Balachandran
Consultant, Liver Transplantation and HPB Surgery, Bangalore.

Thus spake Thomas E . Starzl



On Medical Accountability & Failure

"How many concealed suicides were committed by deliberate drug discontinuance is not known. These deaths almost always were classed as being caused by 'noncompliance.' Doctors, like all other people, do not like to admit imperfections or failure. It was better to blame the patients for their own demise."

Context:

Starzl critiqued the medical community's tendency to attribute patient deaths to "noncompliance" rather than acknowledging systemic or professional shortcomings.

THE ANATOMY OF CONSENT

The cultural context influencing process of obtaining informed consent in India

Cultural context and family beliefs and practices have a great influence on the process of obtaining informed consent for surgical procedures in India., The questions which often arise are, who should inform, to whom should we inform and how much information to give for getting consent.

In USA and most other western countries for instance, patients would like to know the full details of theimplications of their disease and the details of the proposed treatment and expected outcomes, before giving consent. Their attitude to life permits them to receive what may be not so good news. No information can be given to the caregivers without consent of the patient violating their privacy. Also, since most expenses are covered by insurance, cost is not often a factor for consideration in giving treatment options to the patients.

In India, the situation is totally different. Some of these are, wrong beliefs held by doctors and cultural context and values and beliefs of the family which contribute to the difficulty of getting informed consent; Some of these situations are highlighted hereinafter:

i) A belief, often held by young surgeons, that poor patients in particular, are not aware enough of the nuances of medicine, to understand the consequences of what is being discussed with them and hence a paternalistic attitude is justified. The doctor assumes that patients and caregivers are incapable of understanding the nuances of the disease and its management and therefore, gives minimal information and himself takes what he considers to be an informed decision in the best interests of the patient.

ii) A belief that costlier options of management with minimal benefits, if any, like monoclonal

antibodies in advanced disease, need not be discussed since the doctor makes the decision that the patients cannot afford that particular form of treatment which may result in a financial calamity to the family. Hence discussions around these options are avoided for “those considered poor and ill informed”.

iii) There is great reluctance on the part of doctors due to perceived shortage of time, for a detailed discussion on the pros and cons of the treatment with patients, resulting in the process of getting informed consent being often left to nurses or junior doctors who come with a printed form for a mere signature of approval. In the consent form, which was brought by a nurse, before the cataract operation of one of my relatives, the first two clauses were: a) you may lose the sight in the affected eye

due to infection and b) you may lose sight in the normal eye also because of sympathetic ophthalmitis. Neither the patient nor the care givers were able to understand these clauses and were reluctant to proceed with the procedure which they had been told was relatively safe.

iv) Sometimes the patients are themselves unwilling to discuss in detail the expected outcomes, particularly if the outcomes are not uniformly rosy, and request the doctors to discuss with the care givers instead. In some instances, the caregivers themselves may insist that no adverse outcomes be discussed with patients who will not be able to take the bad news and thus offer to make the decisions on behalf of the patients. This seemingly violates ethical guidelines.

v) Our culture is also such that doctors themselves do not often like to give what could be perceived as bad news directly to the patient (such as announcing the presence of widespread metastases precluding treatment) and would rather prefer to discuss the issue with the relatives.

vi) After long discussion and apparent consensus with one set of relatives, new relatives may appear who want full information before any intervention and the whole process has to be repeated.

These are habitual happenings in the Indian context to which all physicians need to adapt. If the patient does not want to know about the implications of the clinical condition, then the discussion must perforce happen with relatives. Such an eventuality is not uncommon. On the face of it, it may appear unethical to not inform the patient. Undeniably, it would be preferable to always have the patient in the discussion group. However, the situation of withholding information from the patient may be forced on the doctors by the family.

In this context, to safeguard the ethical domain of informed consent, the instructions of the family to be the decision makers and the express instruction of the patient to withhold himself / or herself from the discussion group must be recorded in the consent form and the patients' signature must be obtained on the form.

It is the duty of physician to discuss all options and not appear to be the advocate of one choice. All options must be placed before the care givers or the patients, as the case may be, and the expected outcome with each option and need for each measure discussed with all questions answered and all clarifications given. If the expected outcome is very meager, say with a monoclonal antibody which is expensive but is likely to benefit only about 5% of the patients, that also needs to be told. The doctor, at any time, should not take it on himself / herself to make an economic decision on behalf of the family. It is the prerogative of the family alone. One should remember that the choice of treatment and particularly the choice of costly treatment is for the patient and family to make. There is absolutely no role and no protection from violation of ethics by assuming a paternalistic role and making decisions on behalf of the patient and the family.

It is the duty of physician to discuss all options and not appear to be the advocate of one choice.

As all patients and caregivers may not understand percentage response, the outcome must be defined in common terms like very good, good or minimal or negligible. Often, one would surprisingly find that they are not that ill- informed and are capable of understanding the consequences of their decision. At no cost, is decision making to be taken over by the physician in charge on the excuse of the patients and family not being able to comprehend the true situation or being able to afford treatment. This would raise the possibility of distrust, if treatment goes awry, and

there will be risk of litigation.

There would be situations, where after a long conversation with one set of relatives, another new set would suddenly emerge and take over the decision-making role. There is no alternative to discussing with the new group, if the patient so requests.

Every communication is the responsibility of the principal surgeon and should not be left to the juniors or to nurses. That is a prescription for a disaster.

The Indian context is therefore, very different from that seen abroad and one has to adjust to the cultural peculiarities that one encounters in our country. It is all the more necessary to be aware of these, so that young surgeons in training are aware of the subtle and not so subtle differences in the process of obtaining informed consent in India, all the more, because this aspect is part of the hidden curriculum and not part of the overt curriculum of training for MS General surgery.

Every communication is the responsibility of the principal surgeon and should not be left to the juniors or to nurses. That is a prescription for a disaster.

N. Ananthakrishnan,

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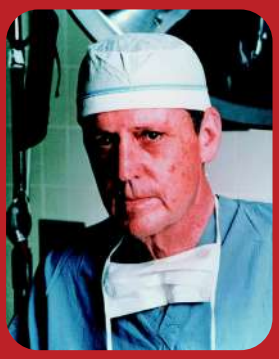
Thus spake Thomas E . Starzl



On the Emotional Burden of Surgery

"When I told close friends that I did not like to operate, they did not believe me... Instead of blotting out the failures, I remembered these forever. With growing concern, I came to believe that I was not emotionally equipped to be a surgeon or to deal with its brutality."

Context:

Despite pioneering liver transplantation, Starzl confessed profound anxiety about surgery's "violence" and his inability to forget failures—a vulnerability contrasting his public persona.

Late Prof. Meenu Hariharan(MGE), former Prof. KT Shenoy (MGE), Former Prof. M. Anandakumar (SGE), Late Prof. N. Rajan (Founder Head, SGE), Late Prof. V. Balakrishnan (Founder Head, MGE), Former Prof. M. Narendranathan (MGE), Dr. Raji (Prov tutor, MGE), Dr. Nandini (Sr. Research fellow, MGE - Rtd as Dy Director- ICMR), Smt. Sosamma (Sr. Lab technician), Dr. Nandakumar (Tutor- SGE) Dr. Jagadeesh (Tutor- SGE), Late Dr. Abdul Kalam (Asst Prof- SGE), Dr. Ravindran(Tutor, MGE), Dr. Balachandran Nair (Tutor-SGE- Rtd in 2007 as Prof of CVTS), Dr. Thankappan (Tutor- MGE: Rtd as Prof- MGE), Mr. Markose Kurien(Sr. Lab tech),and clerical staff

A GOLDEN CHAPTER

50 years of SGE at Trivandrum

The Department of Surgical Gastroenterology, Medical College, Trivandrum, Kerala, celebrated its Golden Jubilee on the 14th and 15th of June this year with a CME programme and Reunion. This was attended by the former Faculty and Alumni apart from the Rtd Nursing and paramedics of yesteryears.

This Department, established in 1975 under the leadership of the late Prof. N. Rajan, was the first such Department in the country dealing exclusively with complex GI conditions needing surgical treatment. Within a few months of its establishment, the Department was busy with patients needing major time consuming GI surgeries.

Shortly thereafter, Dr Anandakumar too joined the Dept apart from dedicated temporary hands who all joined to gain exposure in the early part of their surgical career. With a lot of hard work and toil, the Dept slowly established itself. Working in close unison with the Department of Medical Gastroenterology, established in 1973 by the late Prof. V. Balakrishnan, who was amongst the first in the country to do DM Gastroenterology, the Department was able to provide quality work with good results, resulting in a steady flow of patients.

Surgical treatment for Chronic pancreatitis & Portal hypertension became common place besides surgeries for GI Cancers including Whipples, inspite of being in an era when intraoperative and postoperative monitoring were in their rudimentary

Prok. Okuda leading bedside discussion during ISG National Conf 1981

Surgical gastro enterology unit 1975

Annual conf of ISG 1981

stages.

As a natural fallout of this united work, the Surgical and Medical Gastroenterology Departments jointly organized the 22nd National conference of the Indian Society of Gastroenterology in 1981 in the College campus, which was attended by Delegates from all parts of India and abroad.

Additional Faculty members joined in the 1980s and 1990s including former Faculty, Prof Mathew Koshy, Prof Subhalal, Prof AP Kuruvilla and Prof. Bonny Natesh, the quantum of work improved vastly.

MCh course in the Specialty could be started in 1996 with the persistent efforts of Prof. M. Anandakumar and colleagues, the MCI inspection for the same being conducted by the Late Prof. S.P Kaushik, founder Director, SGPGI.

The opening of the Super specialty block in 2011, as part of the PMSSY (Pradhan Mantri Swasthya Suraksha Yojana) project under the stewardship of the then Principal, Prof. Ramdas Pisharody, was a major milestone in the journey of the Department towards excellence. Equipped with modular operation theaters having laminar airflow, Anesthesia workstations and dedicated well equipped ICUs, the quality of patient care stands vastly improved.

The Department works in close unison with Medical Gastroenterology, Radiology, Anesthesiology and Critical Care and carries out both open and Laparoscopic surgeries covering the entire spectrum of GI Surgery.

It is also to be noted that, of late, the Department has started carrying out Liver transplantation successfully in a public private partnership mode, with the support of the KIMS (Kerala Institute of Medical sciences) , Trivandrum team, a herculean task in a

Late Prof. Meenu Hariharan(MGE), former Prof. KT Shenoy (MGE), Former Prof. M. Anandakumar (SGE), Late Prof. N. Rajan (Founder Head, SGE), Late Prof. V. Balakrishnan (Founder Head, MGE), Former Prof. M. Narendranathan (MGE), Dr. Raji (Prov tutor, MGE), Dr. Nandini (Sr. Research fellow, MGE - Rtd as Dy Director- ICMR), Drs Arun Kumar ML, Shashikiran MS, Shanavaz, Sajeesh Sahadevan, Subhash R, Sylesh Aikot, Fysal K., Sindhu R. S, Roby Das, Santhosh Subramanian, Drs. V. P Madhavan, Deepak Varma, K. Prakash, B. Venugopal, Rtd Prof. N. Subhalal, Rtd Prof. M. Anandakumar, O. V. Sudheer, Baiju Senadhipan, Ramesh Rajan, Joshy John, Drs Raviram. S, Fahaduzzaman, Sreejith. S, Kushal Bairoliya, Iyoob Ali, Subhankar Saha, Shabeerali T. U, Agestino Antony, Arjun Suresh, Bima Maheen, Raheef. P, Byju Kundil

busy 3000 bedded, 75 year old Institution.

Faculty and MCh trainees regularly attend and present their work at National and Regional conferences, as has been the tradition in the Department. The Department has also brought out 25 publications in indexed journals and is currently conducting a Randomized controlled trial in Pancreatic surgery as well as basic research pertaining to MSI in colon cancer.

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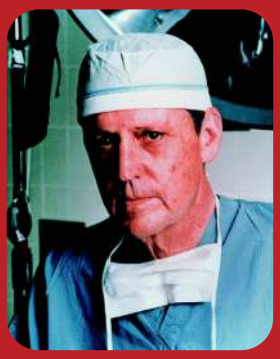
Dr.Ramesh Rajan

Organising Secretary

Dr.Arun Kumar M L

Co- Organising Secretary

Thus spake Thomas E . Starzl

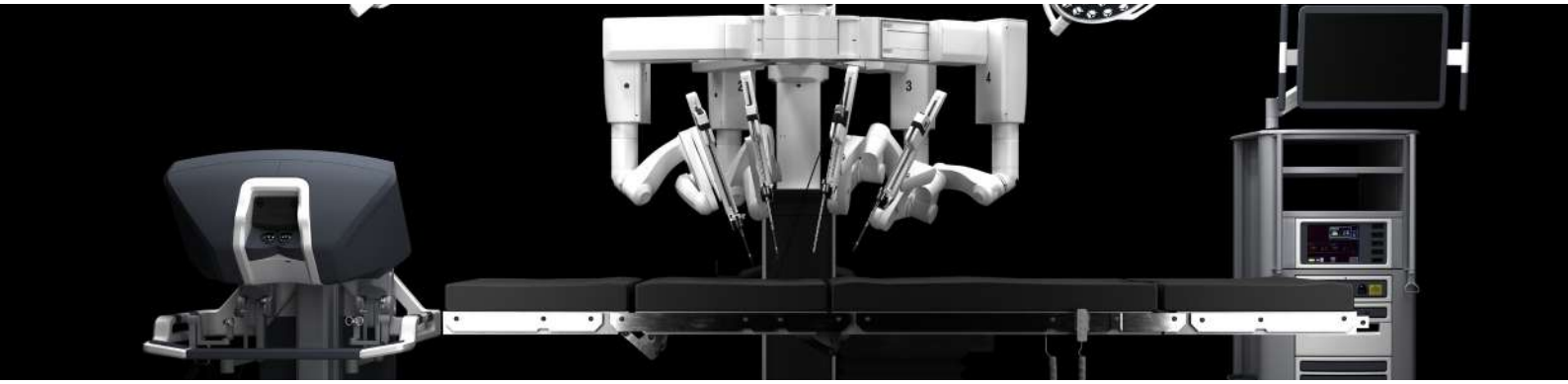


On Patients and Surgeons as "Puzzle People"

"During those years, the patients were not the only puzzle people who were being forged. The surgeons and physicians also changed... Some were corroded or destroyed by the experience, some were sublimated, and none remained the same."

Context:

Starzl described how high-stakes transplant work transformed both patients and medical professionals, often at great personal cost.



BY SURGEON, FOR SURGEONS

SSI Mantra India's First Homegrown Robotic Surgical System

Imagine a world where surgery knows no bounds, where precision meets innovation, and where patient care transcends limits. Robotic surgery, once perceived as exclusive to the privileged few, has evolved to become a game-changer for all - offering a minimally invasive approach with unparalleled depth, precision, and accuracy for all surgical procedures. This vision is now a reality, transforming the future of healthcare. Welcome to the future of medicine, where the SSI Mantra - India's pioneering surgical robotic system - is taking the lead. SSI Mantra is the brainchild of visionary cardiothoracic surgeon Dr. Sudhir Srivastava, with SSI standing for Sudhir Srivastava Innovation.

Founder's story : Dr. Srivastava's journey

Hailing from Jodphur in Rajasthan, Dr. Sudhir Srivastava's remarkable journey began with a move to the United States of America in 1972 for postgraduate studies. He honed his skills in Cardiothoracic Surgery at the University of British Columbia, Canada, before establishing himself as a leading cardiac surgeon in Texas. As the founding chairman of Alliance Hospital, a premier cardiovascular disease center in West Texas, Dr. Srivastava's expertise in robotic cardiac surgeries earned him international recognition. His record-breaking number of robotic Beating Heart Totally Endoscopic Coronary Artery Bypass (TECAB) surgeries is a testament to his innovative approach and technical prowess.

Dr. Sudhir Srivastava's passion for minimally invasive surgeries led him to perform numerous robotic surgeries, with one-third of his cardiac patients recovering quickly enough to go home within a day.

As an expert in the field, he even traveled to India to train doctors in robotic surgeries, starting with his first robotic surgery in the country in 2002, when Robotic Surgery had just been introduced in the country and there was no skilled surgeon to perform robotic cardiac surgeries. He kept coming back to India to train doctors for robotic surgeries. In 2011, he seized an opportunity to launch a robotic cardiac surgical program at one of the major hospital in Delhi, and his long-held desire to be back in India came true.

Dr Sudhir Prem Srivastava, Cardiothoracic robotic surgeon

Igniting change : The story behind SSI creation

A poignant encounter with a 22-year-old patient's family left an indelible mark on Dr. Sudhir Srivastava's career. The young patient, diagnosed with congen-

ital atrial septal defect, required surgery, and the family wished for a minimally invasive procedure.

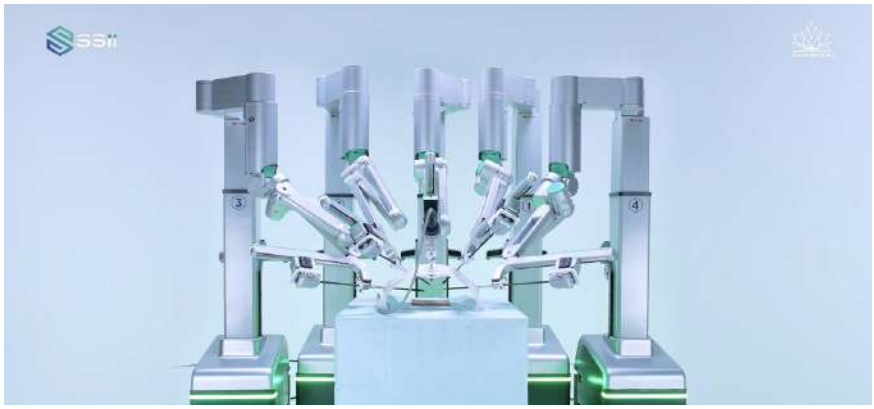
Despite Dr. Srivastava's willingness to perform the surgery pro bono, the hospital's high costs for imported robotic consumables proved insurmountable. The patient's brother's efforts to raise funds were unsuccessful. This experience ignited a mission to develop a cost-effective robotic system tailored to the needs of the underserved within India and across the world. Dr. Srivastava had his struggles, from funding challenges to personal sacrifices. Despite these hurdles, his vision for accessible healthcare drove him forward. With determination and perseverance, he invested his savings, sold personal assets, and borrowed from friends to bring his project to life. His unwavering commitment to making a difference in India has been the driving force behind the SSI Mantra's success.

Dr Sudhir performing robotic cardiac telesurgery for a patient in Jaipur from SSI headquarters in Gurugram

From concept to reality: Its transformation

After decades of unwavering commitment, Dr. Srivastava, now in his late 70s, has brought his life's work to fruition with the third generation of SSI Mantra, including SSI Mudra; the range of over more than 40 plus specialized instruments across specialties including cardiac surgery. With its cutting-edge features, including an open console, sleek 5-arm custom design, a large 3D camera, and advanced AI integration (SSI Maya), the SSI Mantra system enables surgeons to perform procedures with unparalleled accuracy, setting a new benchmark in surgical excellence.

SSI Mantra's advanced technology is designed to elevate surgical precision across various specialties, including complex cardiothoracic, gastrointestinal, gynecological, urological, colorectal, and, head and neck procedures. His vision is clear, if robotic surgery can excel in cardiac care; it has potential to transform other fields as well.



SSI MANTRA 3.0 (Made In India)

His vision is clear, if robotic surgery can excel in cardiac care; it has potential to transform other fields as well

A New Era

SSI Mantra 3.0's standout feature is its trailblazing telesurgery capabilities, showcased by Dr. Srivastava's pioneering work. Notably, he successfully performed a landmark beating-heart surgery between Delhi and Jaipur with imperceptible latency. Another milestone was achieved when a transthoracic esophagectomy was performed remotely over 2,000 km apart, from Delhi to Bangalore, on a patient with esophageal cancer, demonstrating that high-quality care can be delivered uniformly across the country, bridging graphical gaps.

The recently launched MantraM Telesurgery mobile unit takes this vision a step further by bringing a mobile operating theatre to smaller hospitals across

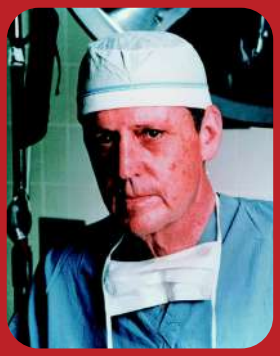
Mantra M Telesurgery Mobile unit launched in March 2025

the country that lack advanced infrastructure, enabling robotic surgeries for patients in need.

SSI Mantra is taking robotic surgery to new heights, with a strong presence in India and a growing global footprint. Its commitment to decentralizing excellence is evident in its expansion to tier-2 and tier-3 cities and remote areas, ensuring equitable access to advanced healthcare. As SSI Mantra pursues international accreditations and collaborations with top institutions, it is solidifying its position as a pioneer in robotic surgery, paving the way for a future where high-quality care is within reach for all.

Dr Nisha Jain
Consultant GI and HPB Surgeon
SKS medical college, Mathura

Thus spake Thomas E . Starzl

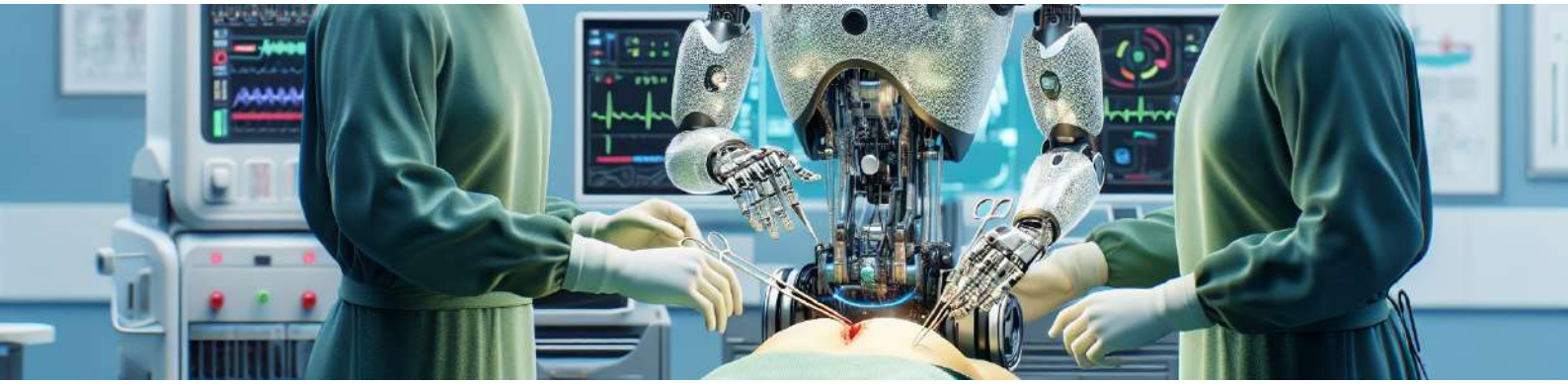


On Legacy and Global Collaboration*

"He had the ability to attract a diverse group from many walks of life... He stimulated his team to superhuman effort by the sheer excitement and sense of importance of the grand experience."

Context:

Colleague Ben Eiseman's tribute to Starzl's leadership, uniting surgeons worldwide to advance transplantation.



SCALPEL TO SOUL

A conversation with Dr Kalayarasan Raja

Soft-spoken and deeply thoughtful, Dr Kalayarasan Raja is a name that commands quiet respect in the world of GI and HPB Surgery. Known for his calm demeanour and surgical finesse, he has grown to become one of India's leading experts in minimally invasive GI surgery. A prolific academic, his contributions to surgical literature reflect a rare blend of clinical excellence and intellectual depth. From humble beginnings, to training at premier institutions, and now to national and international recognition, Dr Raja shares his journey. He discusses his thoughts on surgical training, future directions in the field, and the personal principles that continue to guide his craft.

Gayatri Balachandran (GB) : What drew you to medicine; when and how did surgery start to feel like the obvious path?

H Kalayarasan Raja (KR): My interest in medicine was kindled by some tragedies in my family. I lost two uncles to what I later discovered were preventable deaths – one to an accident and other to infection. Ours was an agricultural family, and most members were not educated. We didn't have access to qualified physicians, and no doubt, there was some mismanagement and delay of care that contributed to these deaths. I was just a 13-year-old boy at the time and it really left a mark. I remember thinking, if we had even one doctor in the family, things might've been different.

As for surgery, it was a surgical clerkship posting in our second year at JIPMER that drew me in. I had seniors who took the time to show me procedures and anatomy, and gave me a real taste of life as a surgeon. Patients with trauma would come in, undergo surgery, and walk out days later. It felt like magic—what surgeons did with their hands seemed godlike. I knew that's what I wanted to do too.

It felt like magic—what surgeons did with their hands seemed godlike. I knew that's what I wanted to do too.

GB : Were there any key mentors or moments that shaped your career path?

KR : My teachers at JIPMER, Prof. Ananthakrishnan and Prof. Vikram Kate, were true mentors in every sense of the word – not just in surgery but in how they carried themselves professionally and personally.

And of course, there was Dr Anil Agarwal, who really broadened my horizons during MCh training.

GB : You trained in two premier institutions in India and then pursued fellowships across the world. How did each of these experiences shape your approach to surgery?

KR : I think every phase of my training has had a definite impact on my career. JIPMER gave me a strong foundation in General Surgery. It was just the right mix of both basic and advanced procedures, with a stepwise ap-

proach. This something I've seen lacking in several other hospitals, where young trainees, fresh and untuned, find themselves overwhelmed by complicated surgeries.

During my MCh training, I gained laparoscopic experience, to which I had very minimal exposure earlier. There was always a dedicated OT just for cholecystectomy, manned by the residents, supervised of course! That really helped my confidence grow. I spent time abroad - in Korea, Japan and the US, training in laparoscopic and robotic surgery. These visits taught me the value of subspecialisation and attention to detail. When you do the same procedure repeatedly, you start refining every step. That precision-focused mindset deeply influenced my style.

GB : How did your interest in minimally invasive GI surgery begin? Was it during your MCh days?

KR : Interestingly, it was from personal experience. During my second year of MS, I underwent open surgery myself. I recovered well, but the whole process- the pain, the tubes, the hesitancy to return to normalcy, was eye-opening. Experiencing it as a patient changed my perspective. I knew I wanted to offer the least invasive option possible to my patients whenever feasible, so that they may have the best possible outcome.

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GB : Wow... thank you for sharing that. That's really a beautiful perspective. Now, you have come such a long way – from small beginnings with laparoscopy, to growing by leaps and bounds in robotics! Congratulations on receiving the Vattikuti Foundation's KS Innovation Award! What was that journey like, and what did it mean to you?

KR : Thank you! It started a few years ago, when a fellow of mine won the national version of the award for our technique of ICG guided segment 4b-5 resection for Gall bladder cancer. Later the award became international and was consistently awarded to European and American surgeons. That became a quiet motivation, as we were doing quality work too, here in India. So, I submitted our self-devised technique for robotic hilar bile duct resection. It was deeply satisfying to bring the prize back to India, especially since the award recognises excellence in robotic surgery from across all surgical specialities, not just GI. This isn't just a per-

On the banks of Yarra river, Melbourne. Oct 2011

sonal milestone; it is proof that innovation in India can stand shoulder-to-shoulder with the world.

GB : You are now recognized

The Vattikutti Foundation KS Innovation Award 2024

nationally and globally for your work in laparoscopic and robotic GI surgery. What was your learning curve like? How did you go about building and refining these skills?

KR : I never focused on numbers. I prefer to break down any procedure into a set of key steps, a checklist of boxes to be ticked. For example, in a gastrectomy: HDL lymphadenectomy, identification and safe exposure of vessels, anastomosis etc. Each step becomes a checkpoint: to test my knowledge of anatomy, my proficiency in doing the step and my ability to overcome difficulty. My goal was to check off each step safely and efficiently. I always review my surgical videos afterwards. Watching yourself operate is humbling. You spot the unnecessary steps and wasted movements. This self-review is vital for improvement and I highly recommend it to anyone looking to advance in MIS. If suturing felt slow, I would practice on the simulator.

If anatomy was unclear, I would revisit videos or literature. Even at this stage in my life, I edit all my videos. I find the self-evaluation is far more enlightening that in asking a resident to do it for me.

Observing other surgeons is helpful too, although it often requires a second visit to really absorb the finer points of technique, after having attempted the procedure yourself. Learning curves vary with individuals and institutions. I think the most important point is having a set of targets for each kind of surgery and going about achieving those targets safely.

GB : Is it safe to say that robotic surgery will become the standard of care for complex GI surgeries soon? Is it something that needs to be introduced during training itself?

KR : Absolutely, for complex surgeries, like in the lower rectum, hilum, anything in the thoracic cavity, or a for a particularly difficult anastomosis. The vision, precision and ergonomics are unparalleled. Anyone who feels strongly enough to criticise a new technology, should do so only after using it. Surgeons should be trained in open, laparoscopic and robotic surgery. Only then can one choose what's best for a patient, without bias. The debate between robotic and laparoscopy today is all about cost. If you remove the cost factor, the choice becomes simple - Complex surgery? Go robotic. So, to answer your question, yes, robotic surgery is the way of the future. And yes, every trainee, if given the opportunity, should get exposure to robotics.

GB : You have developed an advanced MIS practice in a high-volume government setup at JIPMER. What were the biggest advantages as well as challenges you faced?

KR : When I joined JIPMER after training in Korea, all we had was a 14-inch TV monitor and a very basic laparoscope system.

Needless to say, it was disappointing. Fortunately, the administration was supportive, and we gradually upgraded to a HD laparoscopy set. The main challenge in public hospitals is bureaucracy. You can get what you need, but through long tedious processes. The biggest advantage? Your sole focus is the patients' medical needs, regardless of their financial situation. Unlike in private hospitals, where costs are a huge consideration in every decision. If I want to offer a patient robotic surgery, I can do it purely on clinical grounds, and not on what they can afford. That freedom is priceless.

GB : You trained in GI surgery when it was still a young speciality; just five MCh seats nationwide back then! Now, with over a hundred MCh and DNB seats, how do you view this rapid expansion? Is it good for the field or does it come with concerns about training quality?

KR: We needed more seats, no

doubt, because five candidates a year was certainly insufficient for a country like ours. But the growth was too sudden and not backed by proportional expansion of infrastructure: OR time, beds, faculty.

That's where the system has faltered. Many centers doubled or even tripled intake, without expanding capacity. This compromises training. We now see the consequences: MCh residents needing to be trained almost like MS students in their first year before they tune into the system and perform adequately. This is the downside of disproportionate increase and we need to overcome that.

GB : As a teacher and mentor, what values or habits do you try to pass on to your trainees?

KR : Simple. It's what my teachers taught me: treat every patient as you would your own family member. If that guides your decision-making, you'll rarely go wrong.

GB : Do you think simulation and dry labs should be mandatory in all MCh/ DrNB GI surgery training programs?

KR : Yes, I do. In fact, we have proposed and partly implemented a stepwise training model for the surgical curriculum. It starts with endotrainers, along with use of tissue-based models for open surgery.

While VR simulators are available, most devices are quite expensive. Then we move onto animal models, which are useful to learn live tissue handling and bleeding management. Then comes training on cadavers using soft embalming methods. We collaborated with our anatomy department in this regard and have even published our experience with cheaper embalming methods like Genelyn. Ideally, all trainees should go through this sequence. Simulation is not a luxury but a necessity for safe learning today.

GB : You have published extensively despite a heavy clinical load. How do you strike a balance between practice and academic work?

KR : Frankly, it can be challenging. There's no easy solution, no magic trick. It requires effort, consistency, and time - time away from clinical work and family. Usually, I devote some time every evening after the day's work is done, or in the night after everyone at home is asleep. It is difficult, especially for surgeons, but I think if you consider it a priority, you will make time.

GB : How is AI going to change the landscape of GI surgery as we know it?

KR : AI is already streamlining how we work, especially in literature review. I use it regularly, and it's far quicker than traditional searches using Google. For medical literature, I find Scispace more reliable than general tools like ChatGPT. When it comes to surgery itself, the real breakthroughs will be in AI-assisted, image-guided procedures and predictive intraoperative models. I have had discussions with professionals both in India and abroad, who are developing these systems. While there's a lot of promise, these models are extremely complex to build and validate. So, while AI will certainly be part of surgical practice in the future, we're still a few steps away from fully integrating it into the OR.

GB : You have said before that subspecialisation is the way forward in GI surgery. Do you still feel this way?

KR : Yes, I do. But it can be challenging. Personally, I would love to focus on pancreatic surgery, but in our setup, it's not practical. We run the GI surgery unit, and for true subspecialisation, you'd need 7 to 8 faculty, each dedicated to an area : upper GI, colorectal, HPB, transplant, and so on. That kind of structure isn't easy to implement in most Indian insttutes, or even corporate hospitals.

Moments in Korea

Additionally, if you get too narrowly focussed, you might get tunnel vision and miss the bigger picture. So, a broad-based training is essential. Over time, you can refine your focus. There is no question that subspecialisation brings perfection, deep thinking

and innovation. Ultimately this translates to better patient outcomes.

GB : What's a typical day like for you, both in and out of the OR?

KR : I'm in the hospital by 8 am. The day starts with an academic session, which I enjoy – its dedicated teaching time. Then I move between OPD and OR on alternate days. I also handle administrative work; I'm currently in charge of our hospital's IT and health information systems, which often takes up more time than planned.

I set aside an hour after work in the evenings for research or manuscript-writing and usually reach home by 7. My daughter insists I help her study. She says, "Unless you teach me, I don't understand!" So that's a daily ritual. I end the day around 11 PM.

GB : Outside of surgery, what helps you relax or recharge?

KR : I go back to my roots. Sundays, I'm at my farmhouse, spending time farming. I find it meditative and it connects me to my family's agricultural background

GB : If you could have a "superpower" unrelated to medicine, what would it be?

KR : Multipresence! So I could do my work and still spend more time with my family. I think most surgeons would wish for that.

GB : If you weren't a surgeon, what other profession might you have pursued?

KR : Something related to plants, maybe Agriculture or Biotechnology. That was my second choice if I hadn't gotten into medicine.

GB : Do you have a go-to scrub playlist? Or do you prefer a silent OR while operating?

KR : No. Some anesthetists play music, but I find it distracting. I like listening to music sure, but I'm not used to it while working. So, I prefer silence in the OT.

Receiving FRCS Ed, 2023

GB : What's a non-medical book, movie or piece of art that has influenced you or your approach to life?

KR : Honestly, I don't read a lot of non-medical literature. I rarely watch movies, but when I do, it's comedy only; life already has enough stress! I have always been into sports though, especially team sports. That's where I get my never-give-up mindset. In surgery, too, you give everything you've got for the team : your patient, your colleagues, your trainees.

GB : If you could go back in time and give your younger self one piece of advice, what would it be?

KR : Don't wait for perfect conditions to start something. Early in my career, I'd think, "I'll start laparoscopy once everything is in place." But now I believe you must start with what you have. Build as you go. You don't need perfect tools to begin. Also, think of yourself as a leader already. Not out of ego, but to build confidence and take responsibility to teach and share what you know.

With Prof Michael Kendrick at the Mayo Clinic, Rochester - 2018

GB : What legacy or impact do you hope to leave in the field of surgical gastroenterology?

KR : While training abroad, it struck me how the system ensured basic concepts were strong and surgeons learnt the right way from day one. I don't know if everyone Zeel in India, many of us learn things a certain way, only to find it was not the best way of doing things and then have to unlearn and relearn later. I'd like to change that. I would like to help build a standardised system where trainees in India learn the correct way, right from the beginning of their journey. That's the legacy I would want to leave.

Interviewed by

Dr Gayatri Balachandran

Consultant, Liver Transplantation and HPB Surgery, Bangalore.

Winners of TYSA GI Surgery

TYSA 2015	Dr. Name	City
TYSA GI Surg	Dr. Rahul	Lucknow
	Dr. Nikhil	Mumbai
	Dr. T Perungo	Chennai

TYSA 2016	Dr. Name	City
TYSA GI Surg	Dr. Nikhil Chopra	Lucknow
	Dr. Abdul Rehman	Chennai
	Dr. Yogesh Bang	Hyderabad

TYSA 2017	Dr. Name	City
TYSA GI Surg	Dr. Shashikiran	Thiruvananthapuram
	Dr. Aviral	Hyderabad
	Dr. J R Livin Jose	Chennai

TYSA 2018	Dr. Name	City
TYSA GI Surg	Dr. Pavan Kumar	Lucknow
	Dr. Vikram	Coimbatore
	Dr. Azaz Ahmed	Chennai

TYSA 2019	Dr. Name	City
TYSA GI Surg	Dr. Kushal Bairoliya	Trivandrum
	Dr Ajay Pai	Lucknow
	Dr Kanchan A Sachanandani	Chennai

TYSA 2020	Dr. Name	City
TYSA GI Surg	Dr. Nalinikanta Ghosh	Lucknow
	Dr. Pananilath Fahaduzzaman	Trivandrum
	Dr. Sreesanth K S	Jodhpur

TYSA 2021	Dr. Name	City
TYSA GI Surg	Dr. Jaya Agarwal	Ernakulum
	Dr. Yash Sinha	Lucknow
	Dr. Vipin Sharma	Lucknow

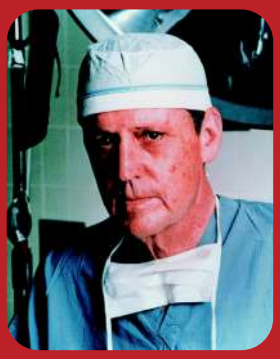
TYSA 2022	Dr. Name	Dr. City
TYSA GI Surg	Jazeel S A	Kochi
	Satish Durgesh	Pondicherry
	Khamar Jaha Banu	Salem

TYSA 2023	Dr. Name	Dr. City
TYSA GI Surg	Dr. Yuvaraj T	Mumbai
	Dr. Amarsinha Bhimrao Shingade	Mumbai
	Dr. Yajnadatta Sarangi	Lucknow

TYSA 2024	Dr. Name	City
TYSA GI Surg	Dr. Eswaravaka Saikrishna	Jodhpur
	Dr. Bijit Saha	Patna
	Dr. Theakarajan	New Delhi

CLICK THE THUMBNAIL TO OPEN THE VIDEO

Thus spake Thomas E . Starzl



On the Ethical Weight of Innovation

"The mortality from the failed early trials... did not mean that liver transplantation was causing deaths. These patients were under a death sentence already because of the diseases that had brought them to us."

Context:

Defending transplants against accusations of futility, he reframed failure as necessary pursuit of hope for terminal patients.

INTERNATIONAL OBSERVERSHIP TO KOREA: 2025

Dr. Kaival Gundavda, Mumbai, India

The Korean Association of Hepato-biliary and Pancreatic Surgery (KAHBPS) offers a 1- month international observership programme for candidates from around the world. The application is usually announced in September each year, when applicants are requested to send their documents to the KAHBPS secretariat via email. This IOTK programme offers selected candidates an opportunity to observe HPB surgeries at a centre of their preference, a scholarship of 2,000,000 KRW, and free registration to the HBP Surgery Week. The list of training hospitals and PIs is available on http://www.kahbps.or.kr.

My observership in Seoul, Korea under the IOTK programme was a deeply enriching and transformative experience, both professionally and personally. I had the privilege of being mentored by Prof. Chang Moo Kang at Severance Hospital, one of the leading centres for pancreatic surgery in Asia. The opportunity to witness firsthand the precision, innovation, and surgical expertise of such a high-volume centre was truly inspiring. The observership offered an immersive exposure to advanced surgical techniques, multidisciplinary patient management, and the culture of academic excellence that defines Korean practices.

A major highlight of my time was the operating theatre experience with Prof. Kang, where I observed several complex pancreatic procedures. Watching him perform a laparoscopic Whipple's procedure was particularly awe-inspiring- the finesse, clarity of dissection, and smooth coordination within the surgical team were nothing short of a masterclass in minimally invasive pancreatic surgery. On other days, I had the privilege of observing Prof. Choi performing advanced liver resections. Prof. Choi's meticulous handling of liver parenchyma and his use of innovative tools in complex resections expanded my understanding of hepatobiliary surgery.

A glimpse of my time at Severance Hospital, Seoul.

Camaraderie developed between International observers and Fellows in the Department of HPB Surgery at Severance Hospital.

(Left to right: Dr. Su Hyung Park, Dr. Martin Christobal, Dr. Kaival Gundavda, Dr. Cho, Dr.Yeonsu Kim)

Another enriching aspect of my visit was attending the Korea HPB Surgery Week, a premier academic conference that brought together leaders in hepatopancreatobiliary surgery from across the world. The scientific sessions were of the highest standard, offering cutting-edge updates in liver, pancreas, and biliary surgery. It was an honour to present

With Professor Chang Moo Kang in the Operating Room.

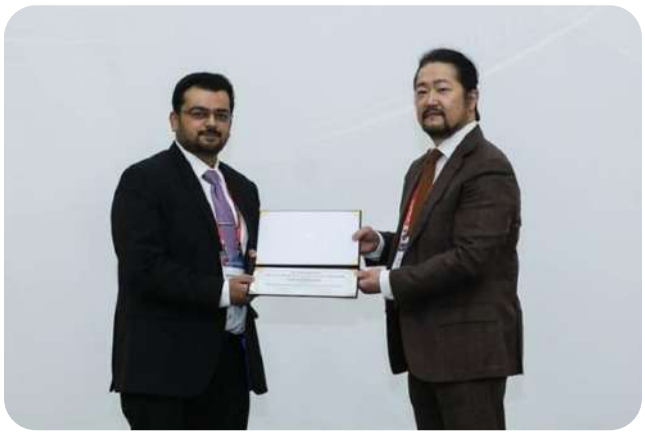
my work at this prestigious platform, and I was deeply humbled to receive the award for Best Oral Paper.

The conference also enabled me to network with experts, discuss new ideas, and gain insight into the future directions of HPB surgery worldwide.

Beyond the operating rooms and conference halls, what made the observership truly memorable was the warmth and kindness of the people I met. The residents, fellows, and support staff at Severance Hospital were incredibly welcoming and always ready to answer my questions, engage in discussion, and help me feel at home. Their camaraderie, professionalism, and dedication to learning left a lasting impression on me. Despite the language barrier at times, the universal language of medicine and shared passion for surgery created strong connections. The friendships and professional bonds formed during this brief period are ones I will cherish with great gratitude.

In summary, the observership in Korea was an exceptional opportunity that enhanced my clinical skills, broadened my academic perspective, and connected me to a global network of brilliant, compassionate professionals. I return home with new knowledge, lasting memories, and renewed motivation to grow as a GI and HPB surgeon. I am forever grateful to the Korean Association of Hepato-Biliary and Pancreatic Surgery for this opportunity.

Being awarded the certificate of Fellowship completion by Professor Kang.



Best Oral Presentation at the HBP Surgery week

Dr. Kaival Gundavda

DNB, MCh Surgical Oncology, DrNB, MRCS,
FEBS Postdoctoral fellowship in GI and HPB Surgery,
Tata Memorial Hospital, Mumbai, India.
Consultant Gastrointestinal and HPB Surgical Oncologist,
Specialty Surgical Oncology, Mumbai.

For my colleagues wishing to connect regarding the Korea HBP fellowship,

Please feel free to reach out to me at gundavdakaival@gmail.com or on social media platforms.

X: @Kaival_Gundavda | LinkedIn: www.linkedin.com/in/kaival-gundavda-148a81248

WOMEN IN GI SURGERY AND LIVER TRANSPLANTATION (WIGIL)

'What, When, Why - Everything you wanted to know about WIGIL'

If you've already heard of WIGIL, it means we're on the right track.
Nevertheless, we urge you to read on.

What is WIGIL?

WIGIL is a group of women surgeons specialising in the fields of surgical gastroenterology and liver transplantation.

How did it happen?

WIGIL was born out of multiple meetings spanning over three years with lots of encouragement from surgeons of both the genders, leading to the formation of a task force in August 2024. The name and logo were created after consensus from the task force.

Why WIGIL?

Because women in surgery, and in gastrointestinal and liver transplant surgery in particular, often have to navigate a range of issues that are not readily visible to their male counterparts, yet play an important part in how their careers and lives shape up.

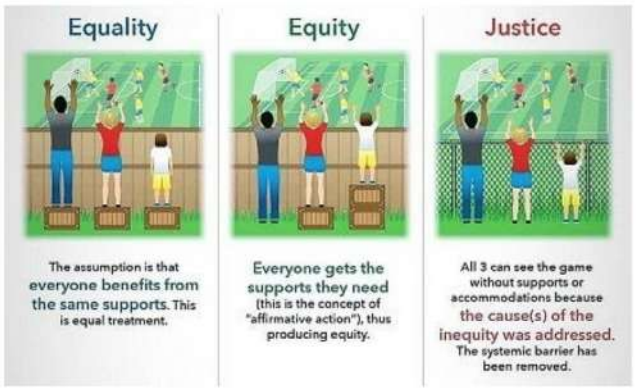
What kind of issues?

- Biases – implicit more than explicit
- Gender-based / societal expectations
- Lack of female role models especially in administrative positions
- Lack of adequate support at work and home with familial responsibilities taking a toll on career growth
- Lesser time to pursue academic writing and publication
- Difficulty in attending conferences leading to lower visibility and recognition
- Reduced networking opportunities and inability to attend informal networking events after working hours

Meritocracia, artist - carlin, source : https://www.theline.org.au/exploring-power-and-privilege/ (Open source)

What are the goals?

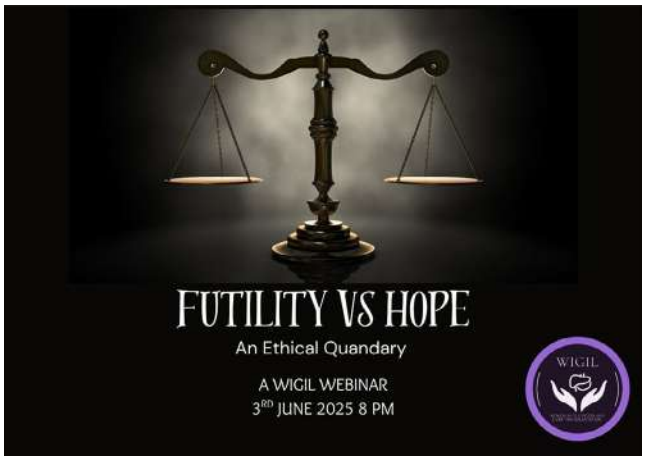
- Work towards achieving gender equity and inclusivity in the workplace
- Foster communication and collaboration with each other and address gender-specific issues
- Enhance visibility of our members through academic activities and in conferences
- Support the advancement of women surgeons to leadership roles



Artist unknown, source :https://www.theline.org.au/exploring-power-and-privilege/ (Open source)

What are the plans going forward?

- Inspire more young women to take up surgical gastroenterology and liver transplant by increasing the visibility of women surgeons as role models
- Help them embrace their unique skill set and not get demoralized by gender stereotype based discouragement
- Promote academic progress of women surgeons
- Increase mentorship and leadership opportunities for women
- Become a body of support for all its members, irre spective of the stage of their careers
- Organize academic events including webinars and conferences




IASGCON, Kolkata, October 2022


APHPBA, Bengaluru, September 2023

IASGCON, Hyderabad, November 2023

For our academic sessions, we do try to curate pertinent topics that are of interest to every surgeon irrespective of gender, and we urge all the readers to partiipate enthusiastically.

Sravanti Balaga
Assistant Professor, Department of Surgical Gastroenterology,
Visakha Institute of Medical Sciences,
Visakhapatnam

Manpreet Uppal
Assistant Professor, Department of Surgical Gastroenterology, AIIMS Nagpur

We hope to see you soon at the next WIGIL event!!!

Email ID: womeningisurgery@gmail.com
Facebook page: Women in GI Surgery and Liver Transplantation – WIGIL - India
Instagram: @wigil_india | X (Twitter): @WIGIL_India | YouTube: @WIGIL_India

LIVER TRANSPLANTATION IN INDIA

'The history of liver transplantation in India is a story of late beginnings, determined pioneers, legislative reforms and rapid expansion, culminating in India becoming a global leader in living donor liver transplantation (LDLT).

Dr Thomas Starzl performed the world's first successful liver transplant in 1967 in the United States. After a few initial hiccups, the western world picked up and by the late 1980s, a large number of liver transplants were being performed in Europe and the USA , with an 80% success rate and 70% 5-year survival rate.[1]

However, due to the complexity of the procedure, the need for specialized infrastructure, and ethical and logistical challenges surrounding organ donation, it took a few decades for the surgery to be introduced in India. It all began with the efforts of medical pioneers such as Prof. S. Nundy, when the Transplantation of Human Organs Act (THOA) was passed in 1994. This landmark legislation recognized brain death and provided legal framework for organ transplantation in India.[2],[3].

First Transplants - Trials and Breakthroughs

Once legal safeguards were established, liver transplant efforts commenced. Early attempts, carried out at Apollo Hospitals in Chennai and AIIMS Delhi in 1995 and 1996 were unsuccessful, underscoring the steep learning curve posed by this intricate procedure.[4] But it was those initial trials that laid a solid foundation for the future of liver transplantation in India.

The first successful deceased donor liver transplant (DDLT) in India was performed in 1998 at Apollo Hospital, New Delhi.[5]

In the same year, the first successful living donor liver transplant (LDLT) was also performed, marking a pivotal moment in the history of Indian transplantation.[6]

In the early years, only 131 liver transplants (deceased-donor and living-donor combined) were performed across 15 centres, amid low public awareness and limited organ-donation infrastructure.[7]

Expansion and Innovtions (2005–2015)

The following period from 2005 saw a dramatic increase in the number and success of liver transplants in India. Surgeons, who were now trained from renowned national and international centres, began to adapt and refine techniques suited to the Indian context, particularly LDLT.

By 2007, a total of about 340 liver transplants had been conducted across 22 centres in India, with living donor liver transplantation (LDLT) constituting the majority of these procedures.[8] The prominence of LDLT was particularly significant, given the persistently low rates of deceased organ donation, due to cultural prohibitions, logistical limitations and lacking awareness.

Indian surgeons rapidly developed advanced expertise in LDLT, achieving survival rates and clinical outcomes

comparable to leading international centres. The volume of liver transplants continued to increase, reaching approximately 1,300 procedures by 2014, with LDLT accounting for 85% of these cases. This period also witnessed the establishment of additional transplant centres, especially in Delhi and the National Capital Region, alongside a gradual rise in deceased donor liver transplantation (DDLT) in southern states such as Tamil Nadu.[4]

Current Status (2015 – present): India as a Global Leader

Today, India has more than 200 registered liver transplant centres, spread throughout the country. Delhi-NCR alone is home to more than 15 centres offering advanced liver transplantation facilities.

In 2022, India performed a total of 3,911 liver transplants, the third largest number, only short of USA (9,528) and China (6,053). (Fig. 1) Notably, India performed the largest number of living donor liver transplants globally (3,174 in 2022), a testament to the expertise of Indian surgeons and the adaptability of the healthcare system.[2]

India now has more than 25 liver transplant centres performing minimally invasive donor hepatectomy (MIDH), using laparoscopic and robotic approaches to enhance donor safety and recovery. The experience gained is now being effectively translated into robotic recipient liver transplantation, marking a significant advancement in surgical precision and minimally invasive transplantation. A notable example is Rela Hospitals in Chennai, where a robotic auxiliary liver transplant was recently performed on a five-year-old patient, with both the donor and recipient surgeries conducted using robot-assisted.

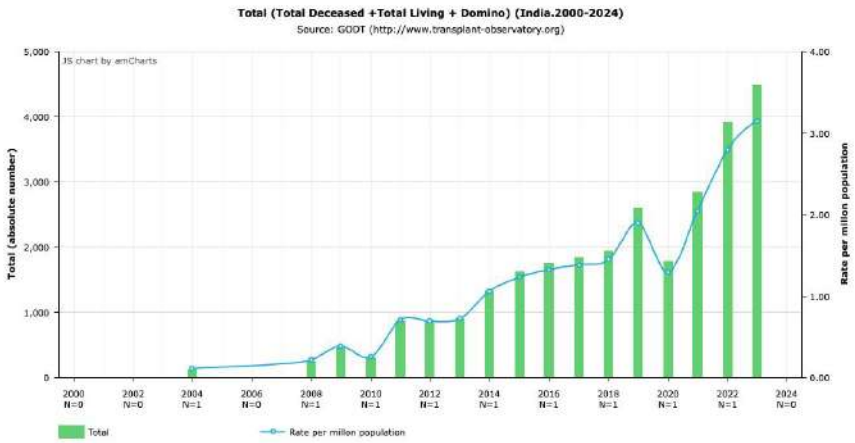
Indian authors have contributed significantly to the global liver transplant literature, with a total of 2,449 PubMed-indexed publications which include 58 clinical trials, 595 review articles, 350 case reports, 66 editorials, and numerous original research articles.[2]

This academic output continues to grow steadily, reflecting ongoing advancements and active research in the field.

The Liver Transplant Society of India (LTSI) was formally established in 2018 with the aim of constituting a multidisciplinary professional body uniting surgeons, physicians, anaesthetists, intensivists and other healthcare professionals dedicated to advancing liver transplant practice. The society plays a pivotal role in shaping medical education, developing training curricula, and promoting competency-based professional development.

LTSI has established a robust fellowship program, attracting both domestic and international trainees. These programs provide structured, hands-on training in advanced surgical techniques, perioperative management, and multidisciplinary care, ensuring the development of highly skilled transplant professionals.

The Indian Liver Transplant Registry (ILTR) is another essential initiative that systematically collects, analyses, and disseminates data on liver transplantation activities across India. By maintaining comprehensive records of



Evolution of Liver transplant numbers over last 2 decades

transplant procedures, outcomes, and trends, the registry facilitates research, informs policy decisions, and supports quality improvement initiatives.

On November 15, 1998, Sanjay became the first child in India to receive a successful liver transplant at 22 months of age—24 years later, he is now a qualified doctor saving lives.

Conclusion

The history of liver transplantation in India is a poignant illustration of the determination of its medical professionals, the importance of legislative reform, and the adaptability of Indian medicine. From the first unsuccessful attempts in the mid-1990s to becoming a world leader in living donor liver transplantation, India's journey reflects both its challenges and its achievements. Today, Indian centres deliver outcomes on par with the best in the world, attracting international trainees and offering hope to thousands of patients each year. The continued growth of liver transplantation centres, technical innovations, public awareness and acceptance in deceased donations, will determine the next chapter in this remarkable story.

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CASE IN POINT

Retroperitoneal Tumor: IVC Leiomyosarcoma

Clinical history and presentation

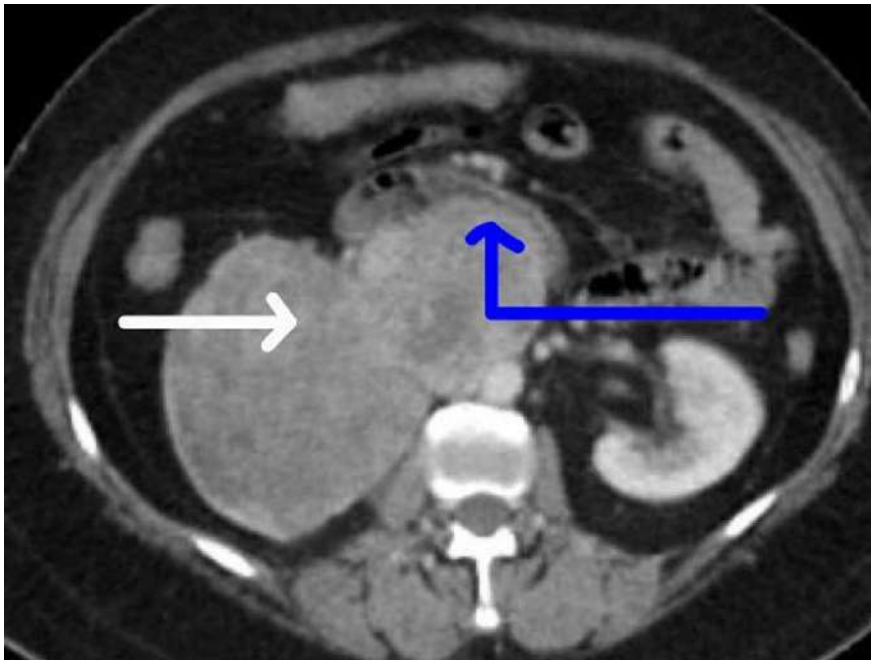
We recently encountered a challenging case of a 51-year-old lady from Kolkata. Her medical history was notable for hypertension, with no prior surgical interventions, no addictions, and no family history of malignancy.

The patient initially presented with post-menopausal bleeding. She did not report any abdominal pain, palpable mass, altered bowel or bladder habits, or lower limb swelling. Her general physical examination was unremarkable (ECOG performance status 1). There was no pallor, pedal edema, or palpable lymphadenopathy. She was vitally stable. Abdominal examination revealed a soft, non-tender abdomen with a bulky uterus.

Diagnosis

An ultrasound-guided biopsy of the retroperitoneal mass was performed. Histopathology was consistent with leiomyosarcoma.

Immunohistochemistry revealed that the tumor cells were positive for smooth muscle actin (SMA), desmin, and H-caldesmon. The MIB-1 labeling index was 30–40% in areas showing the highest proliferative activity.



Pre-neoadjuvant CT scan showing locally invasive enhancing tumor abutting D4 duodenum (white arrow: tumor, blue arrow: tumor abutting duodenum)

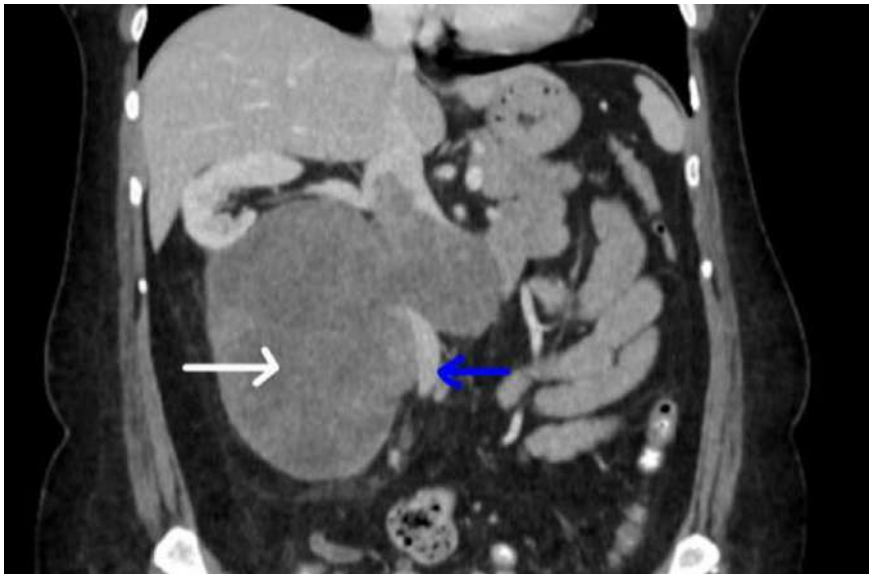
The patient was initially planned for hysterectomy elsewhere in view of a bulky uterus. However, during preoperative evaluation, an abdominal MRI revealed a retroperitoneal mass, prompting further investigation. MRI of the abdomen demonstrated a large retroperitoneal mass measuring 14 × 12 × 8 cm, involving the IVC and associated with tumor thrombus. The mass was abutting the right psoas muscle, the fourth part of the duodenum (D4), head of pancreas, and encroaching on the aorta to less than 180 degrees.

A PET-CT scan was subsequently performed, which revealed a heterogeneously enhancing, large, lobulated, necrotic mass in the right retroperitoneum with significant locoregional invasion. It displaced the right kidney and abutted the psoas muscle, D4 duodenum, and head of pancreas. There was also a possibly metabolically active tumor thrombus within the IVC. The tumor involved the IVC, the right renal vein, and the ostium of the left renal vein. The left renal artery

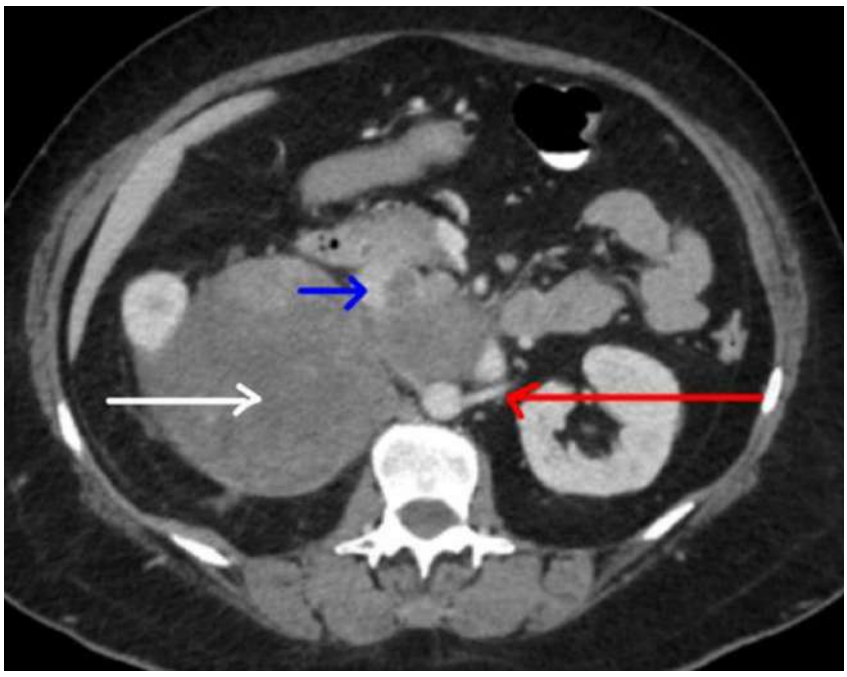
remained uninvolved. No evidence of distant metastasis was observed.

Multidisciplinary Tumor Board Plan

In view of the histopathological diagnosis of IVC leiomyosarcoma and the locally advanced nature of the tumor, the multidisciplinary tumor board recommended three cycles of neoadjuvant chemotherapy (NACT) followed by reassessment with a CECT scan, with surgical resection later if feasible.



CT scan showing tumor, IVC and right renal vein (white arrow: tumor, blue arrow: infra-renal IVC)



Pre-neoadjuvant CT scan showing locally invasive enhancing tumor abutting D4 duodenum (white arrow: tumor, blue arrow: tumor abutting duodenum)

Neoadjuvant Chemotherapy

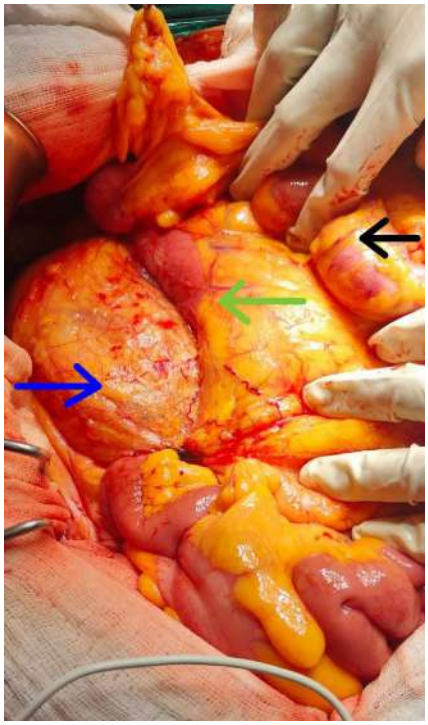
The patient received three cycles of combination chemotherapy with doxorubicin and dacarbazine. A post-NACT triphasic CECT scan performed after three weeks showed stable disease with reduced contrast enhancement of the tumor. There was improvement in the fat planes between the duodenum and pancreas. The right renal artery was noted to course through the tumor, while the left renal artery remained uninvolved. The ostium of the left renal vein was partially involved.

Preoperative Workup

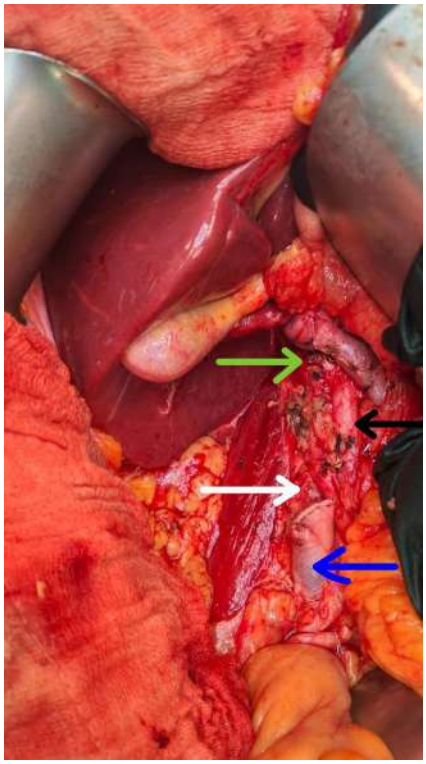
Owing to the good response in scan, patient was planned for surgery. Preoperative laboratory investigations revealed a hemoglobin of 12.9 g/dL, creatinine of 0.67 mg/dL and albumin of 4.2 g/dL. A 2D echocardiogram showed a left ventricular ejection fraction of 55%. A DTPA renal scan indicated differential renal function of 57% in the right kidney and 43% in the left kidney.

Surgical Procedure

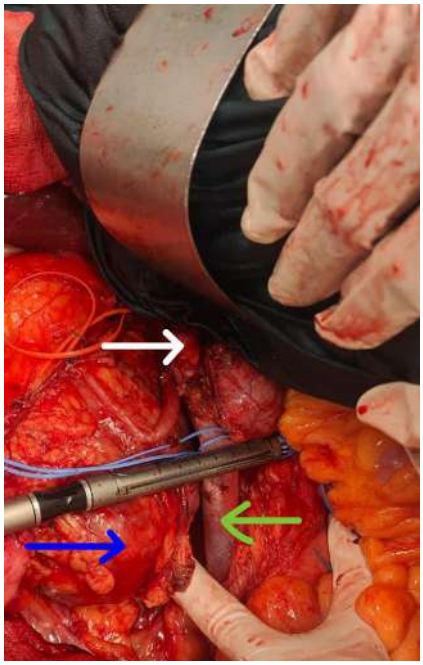
The patient underwent en-bloc resection of the retroperitoneal mass along with resection of the IVC and right nephrectomy. Reconstruction



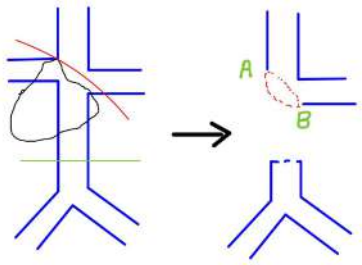
Intraoperative picture of tumor after mobilising colon (Blue arrow: tumor, green arrow: duodenum, black arrow: colon)



Bed of tumor after enbloc resection showing stapled end of infra-renal IVC (blue arrow) and left renal vein-IVC anastomosis (green arrow). Lumbar collateral can be seen draining infra-renal IVC (white arrow). Black arrow denotes aorta



Bed of tumor after enbloc resection showing stapled end of infra-renal IVC (blue arrow) and left renal vein-IVC anastomosis (green arrow). Lumbar collateral can be seen draining infra-renal IVC (white arrow). Black arrow denotes aorta



Diagramatic representation of tumor (black) over IVC and renal vein ostia. Red line denotes cut over suprarenal IVC. Green line denotes stapler over infra-renal IVC. After excision of specimen, anterior wall of IVC and left renal vein were anastomosed (point A to B).

was performed by reanastomosing the left renal vein to the IVC.

The surgical approach was via midline laparotomy. The right colon was mobilized with an extended Kocher's maneuver. The mass was found to be originating from the IVC with extension into

Picture of final specimen

the ostium of the left renal vein, while the left renal artery was free. The right renal vessels were involved.

The infra-renal IVC was stapled, with no reconstruction performed distally due to the presence of adequate lumbar venous collateral drainage. The mass was excised en bloc along with the right kidney and associated vasculature. The left renal vein was partially divided at its ostium, preserving the posterior wall. The anterior wall of the left renal vein was reanastomosed to the IVC, ensuring preservation of the left kidney.

Postoperative course

The postoperative period was uneventful. The patient maintained good urine output with stable renal function. Serial serum creatinine levels remained within normal limits.

Take home message

Our experience suggests that the infra-renal segment of IVC can be effectively decompressed via collateral venous pathways, which gradually enlarge in response to chronic obstruction by tumor. The absence of lower limb edema on clinical examination, along with preoperative imaging evidence of well-developed collaterals, plays a crucial role in surgical planning. Intraoperatively, meticulous preservation of these venous collaterals is essential. This approach allows safe resection of the IVC without the need for reconstruction, thereby avoiding the necessity for long-term anticoagulation.

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Retroperitoneal Sarcoma Surgeon
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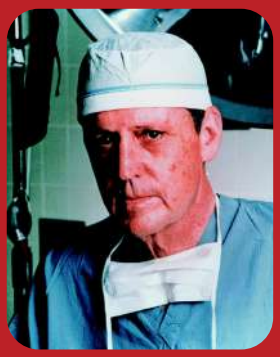
Tata Memorial Hospital, Mumbai

Dr. Pratik Deepak Patil
Fellow, Department of Surgical Oncology
Tata Memorial Hospital, Mumbai

Thus spake Thomas E . Starzl



On Resource Allocation Ethics*

"With livers in short supply, should an elderly person get one?"

Context:

Starzl challenged age-based discrimination in organ allocation, leading to philosophical debates at Pittsburgh.

BRIDGING THE DIVIDE

Advances in the Management of Bile Duct Injuries

Bile duct injuries (BDIs) are among the most feared complications in hepatobiliary surgery, often leaving a lasting impact on both patients and surgeons. As the adage goes, "There are only two kinds of surgeons: those who have experienced a bile duct injury, and those who are likely to." Every laparoscopic cholecystectomy requires meticulous attention and caution, akin to performing the procedure for the first time, given the medicolegal implications and morbidity associated with BDIs.

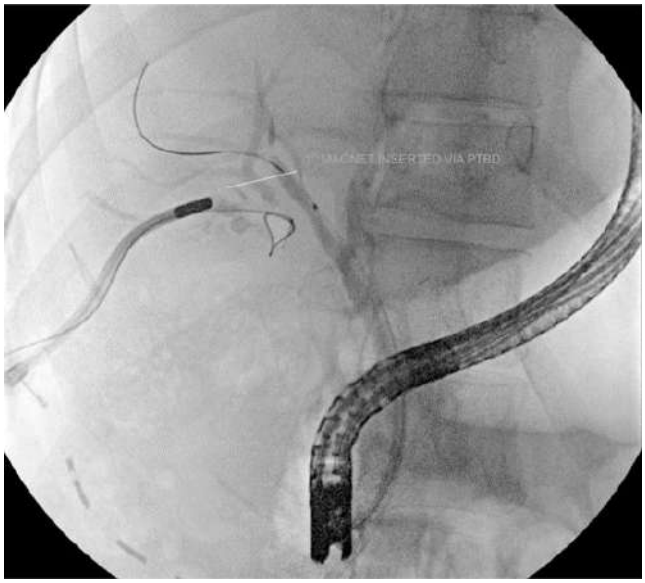
The management of complete common bile duct (CBD) transection remains a subject of debate among surgeons. Some advocate for early repair, while others support delayed intervention. Regardless of timing, prompt recognition of the injury and control of sepsis are critical steps. Restoring bilio-enteric continuity continues to be the cornerstone of definitive management. The gold standard remains a good Roux-En-Y Hepaticojejunostomy.

Significant advancements have been made in interventional radiology and therapeutic gastroenterology, expanding the armamentarium for managing complex BDI's. Rendezvous procedures, which combine Percutaneous Transhepatic Biliary Drainage (PTBD) and Endoscopic Retrograde Cholangiopancreatography (ERCP), have emerged as promising approaches. These techniques facilitate guidewire passage and bridging across transected duct segments, enabling effective stent placement. The use of plastic stents, followed by serial balloon dilatation and multiple stent placements—guided by protocols such as the Costamagna protocol—has shown encouraging results. This is an approach attempted for patient who are not good candidates for or are unwilling for surgical repair. Innovative techniques continue to evolve, including the "Lasso technique" in PTBD, designed to retrieve misplaced or impacted stents. This approach involves passing a guidewire percutaneously into the biliary system, followed by endoscopic snaring of the rendezvous guidewire to restore ductal continuity over multiple stents.

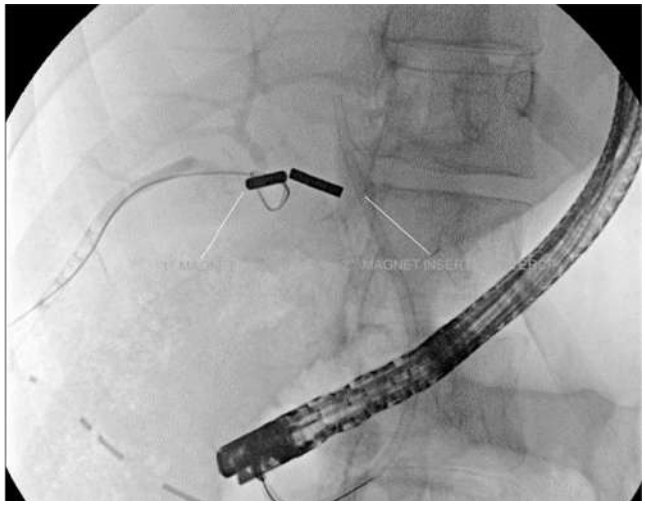
Mexican vaqueros picked up the swinging lasso overhead to round up wayward dogies.

Another exciting development is the use of high-power magnets to create biliary anastomosis across transected ends. After securing PTBD access, one magnet is introduced (Fig.1), and a compatible polar magnet is inserted into the distal CBD via ERCP (Fig. 2), maintained in place by stents. The magnetic attraction gener-

ates compression, facilitating tissue approximation and potentially restoring bile flow (Fig. 3)by passage of multiple stents—an innovative approach demonstrated in preliminary studies.



Magnet inserted percutaneously after securing PTBD access



Compatible polar magnet inserted via ERCP route into distal CBD.

While these techniques are gaining popularity worldwide, data on long-term data on outcomes is still awaited and they still remain largely anecdotal. Furthermore, they are not a one-stop solution and will need a follow up regimen of repeated dilatations and stenting. Undeniably, the innovation behind their conception is remarkable, and in particular, the concept of employing magnetic force to facilitate biliary anastomosis is a promising frontier in interventional and therapeutic gastroenterology, offering hope for avoiding surgical morbidity without compromising on patient outcomes.

Cholangiogram showing smooth passage of contrast into distal CBD after magnetic compression anastomosis.

Bridging the divide

https://youtu.be/mGLNIO6inbU?si=ZW-tkRjexRrjOcT3

Courtesy

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Dr Nisha Jain
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SKS medical college, Mathura

HOT OFF THE PRESS - 1

Structured Exercise after Adjuvant Chemotherapy for Colon Cancer

The **CHALLENGE** trial

Courneya KS, Vardy JL, et al. N Engl J Med. 2025 July 3;393(1):13-25. doi: 10.1056/NEJMoa2502760

BACKGROUND

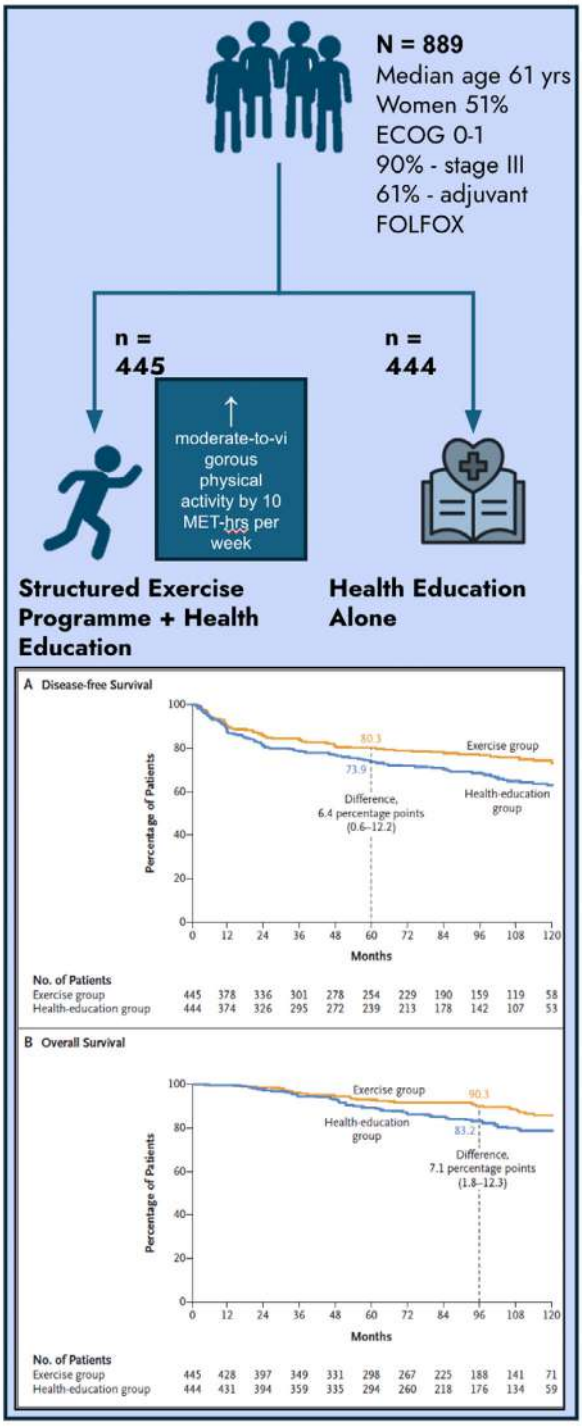
Patients with Stage III or high-risk Stage II colon cancer have 20-40% risk of disease recurrence following standard management with surgery and adjuvant chemotherapy. Interventions that improve survival and quality of life are needed.

CORE ISSUE ADDRESSED

- Compare the effects of providing health-education materials and/or structured exercise regimen, on the survival of patients post completion of adjuvant chemotherapy

METHODOLOGY

- Trial design – Phase 3 multicentre RCT (55 sites in Canada and Australia)
- Funding : Canadian Cancer Society and others
- Patients with Stage III/ high risk II colon cancer, post surgery and adjuvant chemotherapy in the previous 2 to 6 months, and of sufficient performance status, were randomised (1:1)
- Structured supervised exercise programme (every 2-4 weeks for 3 years) or Health education materials only
- Primary end point – Disease-free survival (DFS)
- Secondary end points – Overall Survival (OS), Quality of life (QOL)



RESULTS

889 patients were followed up for a median of 7.9 years. Adherence to mandated supervised exercise sessions was 79% in the first 6 months. DFS was significantly longer in the exercise group than in the health education group (HR 0.72, 95%CI 0.55 to 0.94; P = 0.02). Results of OS (HR 0.63; 95% CI 0.43 to 0.94) and QOL (physical functioning score) were also favourable to the exercise group. Musculosketletal adverse effects were more frequent in the exercise group (19% vs 12%)

COMMENTARY

This is a well-designed RCT with a sound methodology. With a large sample size and a reasonably long follow up period, it provides fairly robust, clinically relevant results and supports the implementation of an intervention with real-world applicability. In fact, the magnitude of benefit delivered by exercise was similar to that provided by most standard chemotherapy regimens. The improvement in DFS was mainly by reduction of distant recurrence and new primaries, with no difference in other causes of death, suggesting that there was a direct impact on cancer-related outcomes, and not just by improving physical fitness and cardiovascular health. The reported modest increase in musculoskeletal adverse effects is far outweighed by the benefits, and are mostly manageable.

The study, however, has focused on a narrow patient cohort of functionally preserved colon cancer survivors and therefore, its generalizability comes into question. Patients were enrolled 2 to 6 months after completion

Of chemotherapy, so those with early recurrences from biologically aggressive tumours were excluded. Although conceptually simple, the execution of structured exercise regimens requires trained professionals, and may place additional strain on an already over-burdened health-care system. Patient compliance is also crucial to reproduce these results.

IMPLICATIONS FOR PRACTICE

With this study, exercise becomes an evidence-based oncology Intervention and not just not supportive care, with definitive impact on cancer survival. The study provides a strong argument for practice change : exercise should no longer just be recommended, but prescribed, and integrated into standard clinical guidelines. It supports investment in infrastructure and personnel training in fitness and rehabilitation, and provides patients a degree of empowerment to effect positive change in their outcomes.

TAKE-HOME POINTS

- Structured exercise initiated within 6 months of completion of adjuvant chemotherapy improves survival in stage III and high-risk stage II colon cancer
- Magnitude of benefit :
- **28% reduction** in disease recurrence/new primary/ death risk
- **37% reduction** in overall mortality risk
- Exercise – not just a lifestyle change, but a tool for survival

Dr Gayatri Balachandran
Consultant, Liver Transplantation and HPB Surgery, Bangalore.

HOT OFF THE PRESS - 2

Real-world Evidence of Porto-Mesenteric Vein Resections with Pancreatectomy and the Development of Predictive Clinical Nomograms for Postoperative Outcomes – An Analysis of 389 Cases: The 'Porto-mesenteric vein Resection- Indian MulticentrE' (PRIME) Study.

Kapoor D, Bhandare MS, et al. Ann Surg Oncol. 2025 Jul 5 | DOI : 10.1245/s10434-025-17702-1

BACKGROUND

With advancement in systemic therapy and surgical techniques, aggressive resections of advanced pancreatic cancer are increasingly being performed. Porto-mesenteric vein resection (PVR) in biologically suitable patients is now considered standard of care.

CORE ISSUE ADDRESSED

- Evaluate the practice patterns, safety and outcomes of PVR in surgery for pancreatic cancer

METHODOLOGY

- METHODOLOGY
- Study design – Multicentre retrospective cohort
- Funding : nil
- Patients with pancreatic cancer who underwent pancreatectomy with PVR with at least 3 months follow-up were included
- Primary outcomes – 90 day post-operative mortality (POM) and major complications(MC)
- Secondary outcomes – Overall Survival (OS), Disease-free Survival (DFS) in patients with Pancreatic ductal adenocarcinoma (PDAC)
- Predictive models for POM and MC

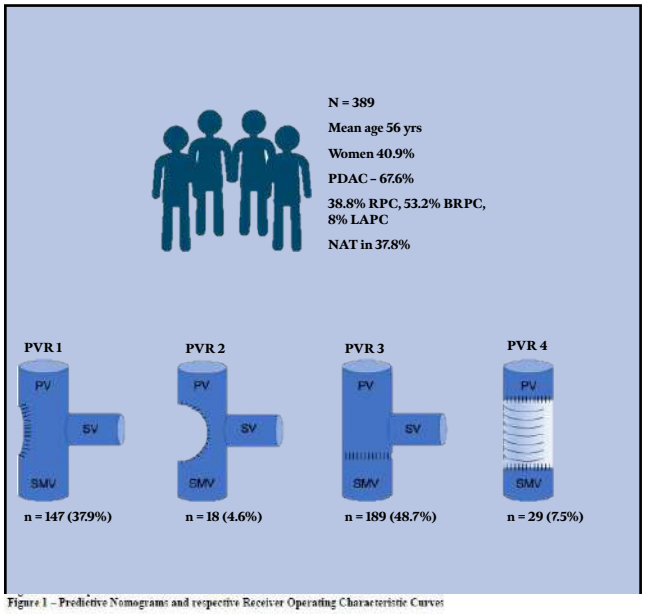
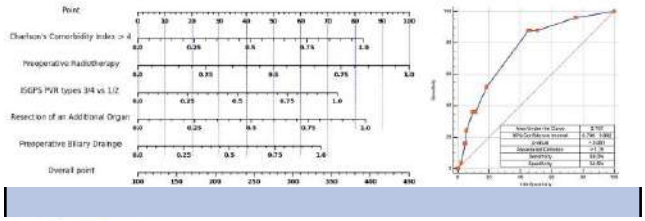
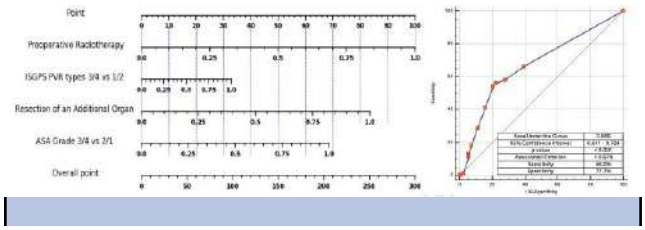


Figure 1 – Predictive Nomograms and respective Receiver Operating Characteristic Curves

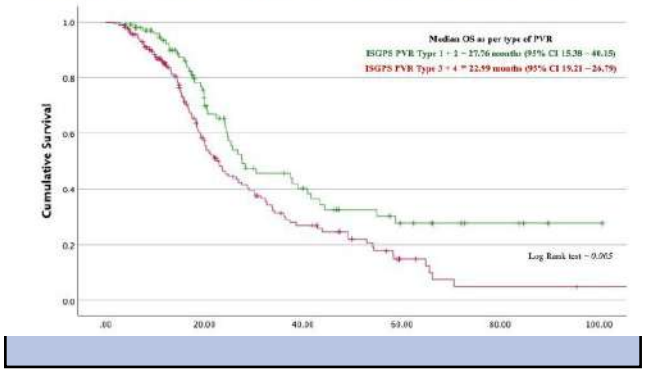
1a - 90-day Postoperative Mortality



1b – Major Complications



Graph 1b – Log-rank test for Overall Survival of Patients Undergoing ISGPS PVR type 1/2 vs 3/4.



COMMENTARY

This cohort study is the first and largest of its kind from our country, pooling the collective results from 11 high-volume pancreatic surgery units. It is a tremendous effort and offers a unique insight into the landscape of pancreatic surgery in India. The nomograms for POM and MC are statistically sound, but the overall number of events is small. Although the final extent of PVR and need for multi-visceral resection is determined on-table, they may be anticipated to a large extent based on quality preoperative imaging, and hence these models may be useful in guiding patient selection. They do, however, need to be validated in larger study populations.

Performing segmental PVR emerged as a key predictor of mortality and poor survival in these patients, although not associated with increased morbidity. This relationship is difficult to explain, although the authors suggest that failure to rescue is what contributes to increased mortality in this subgroup. Additionally, the choice of one type of PVR over another is often a personal decision, influenced by expertise and logistics and is, therefore, subjective. Whether the extent of PVR is a reflection of tumour aggressiveness is unknown, especially since differentiating true wall invasion and peritumoural fibrosis on preoperative and intraoperative assessment is challenging. The study fails to shed light on this matter due to lack of histological confirmation of venous wall invasion. A comparison of survival outcomes with pancreatic resections without PVR would have been useful. An important point brought out is that receiving the full protocol of adjuvant therapy is critical in patients with PDAC with vessel involvement and is a key predictor of OS.

The study's retrospective design carries all the typical pitfalls and biases. There was significant heterogeneity in NAT and surgical protocols across participating institutions. Interestingly, 22 patients underwent pancreatectomy with PVR for non-malignant causes, and in 149 cases the venous resection was unplanned. The inclusion of all types of pancreatic resections in the study group did not seem to influence outcomes, but it is unclear whether the type of primary disease had any impact on postoperative complications, especially post-pancreatectomy fistulae rates.

IMPLICATIONS FOR PRACTICE

The outcomes of pancreatectomy with PVR in high-volume centres in India is consistent with global standards. Postoperative outcomes can be predicted with reasonable accuracy and further studies should be designed to validate the same.

TAKE-HOME POINTS

- Pancreatectomy with PVR can be performed safely in high-volume centres in appropriately selected patients.
- Extensive vein resections carry higher risk of postoperative mortality and failure to rescue.
- Patients can be stratified for risk of postoperative mortality and morbidity with novel nomograms

Dr Gayatri Balachandran
Consultant, Liver Transplantation and
HPB Surgery, Bangalore.

HEALING NOTES

My Mandolin journey

Dr. Deepak Govil

How I got interested

I've always been interested in music. I learned to play the Hawaiian guitar for a while during school. My mother was a very good harmonium player, so I naturally developed a sense of music by listening to her play the harmonium and sing. Although I'm not very good at singing myself, I've always wanted to make up for that by learning to play a good musical instrument.

Once in 2018, I visited a restaurant near Deer Park in Delhi where I heard a young boy playing an instrument with a very melodious voice. He played many of the popular old classics and each one had a very soft and soothing music. We made numerous requests and heard all of our favourite classic songs, waited to hear him play even after we had finished dinner. The restaurant became a personal favourite solely for this music . This was the moment I decided I had to learn this instrument. One of the biggest reasons was how beautifully the kind of songs I love sound when played on it - the melody just comes alive.

The mandolin is quite different from the guitar, and that uniqueness really appealed to me. I wanted to try something different, and the mandolin felt like the right choice.

Since it's not a widely popular instrument, it was a challenge to find a good teacher. Even getting a quality mandolin took time - I had to visit several shops and wait patiently before I found the right one.

My Journey

After extensive searching , I finally found myself a teacher - Shri Mukesh Jolly Ji- who lived quite far from my home. Still, I felt an instant connection, and to my delight, he kindly agreed to teach me. I was overjoyed and began taking Sunday morning classes with him. I'm truly grateful that he took out time for me from 7 to 8 a.m. every Sunday, despite his busy schedule. Also inspite of my repeated requests, he refused to accept any fees. Unfortunately, due to logistical challenges and family commitments, I was only able to attend about 8 to 10 classes. On his recommendation, I bought a basic mandolin. After that, nothing really progressed significantly - except for occasional self-practice.

During the Covid period in 2020-21, our elective surgeries were limited and I tried to utilize this time to learn Mandolin further. I found a guitar teacher Shri Anand ji who was taking online classes at that time. Upon our first interaction online for the class, we both realized that I had operated him for some abdominal issues few years back. A small world it seems!

I took classes with him during this period and learnt with Western notations. He made me learn the basic western notes and some songs. I could practice and brush myself more during this period. My son is a guitar player and helped me thoroughly with my practices too.

Eventually I realised I want-

ed to learn more the nuances and variations specific to Mandolin which is when I was fortunate enough to find Sh Pradipto Sengupta Sir who is a renowned Mandolinist from Mumbai. I am utterly grateful to him for accepting me as his online student. Since I had learnt initially with western notes, I had to unlearn that and start afresh with the Indian notes.

Practicing the basics daily even if it is a bit boring initially is very important. This is the stage when many of the students leave learning these instruments. Everyone wants to learn and play the popular songs. I practiced the basics like Sa Re Ga Ma Pa Dha Ni Sa and its permutations combinations for a long time before taking onto a song.

While learning I made friends with the mandolin group of Sir's students. It's a very interesting group ranging from 18 yrs to 80 years. All are such like minded people that it feels like an extended family.

We started having get togethers in Mumbai and other places. We were looking forward to meeting each other and performances. What I found common in all the persons is that all are simple clear hearted people and could gel very well with each other inspite of different places or profession. We had people from Mumbai, Kangra, Kolkata, Surat, Bhopal and Australia etc. They were Engineers, Doctors, IT professionals etc.

My son in the mean time sent me a very classy Mandolin from US and that further encouraged me. Then we had our first performance as an orchestra created by our Sir. I also gave a presentation on History of Mandolin during this performance with videos and songs incorporated. I myself learnt a lot about history of Mandolin preparing for it and this was a unique experience. First time I performed in front of an audience (350-400) packed auditorium in Mumbai and our orchestra got a standing ovation and lot of appreciation. This was a big booster for us all.

Our recordings of a medley of 3 old classic songs by the orchestra got 1 K views on You tube in a short time further encouraging us. We then made a website –

www.mandolinwondersorchestra.com.

The First time I performed in front of an audience (350-400) packed auditorium in Mumbai and our orchestra got a standing ovation and lot of appreciation.

We last year again had a performance of the Orchestra in Delhi in collaboration with my Hospital and the olorectal cancer foundation which was also very well attended and received. I try to practice everyday preferably even if it is for 15 minutes as persistence is the key to pursue any such thing like any other skill or profession. I am still having regular classes and am learning further skills in Mandolin.

Problems faced and how I dealt with them

Learning these instruments at this stage (60 +) is not easy. As at this age my

finger movement is not as fluent as my fellow mandolin player who is 18 yrs age. But I keep practicing and also do special finger spring exercises to strengthen the muscles

I take special care of my hands and fingers as I am a Diabetic also and am worried

about peripheral neuropathy setting in. Also strengthening my fingers and finer movements help me in minimal access-surgery specially laparoscopic and Robotic Surgery.

Learning these instruments at this stage (60 +) is not easy. As at this age my finger movement is not as fluent as my fellow mandolin player who is 18 yrs age

Family members often get disturbed when you keep playing these instruments and you start hearing comments initially jokingly and then .....So I often practice early morning or late night. I close the room and all the windows creating a soundproof space for playing and recording. Nonetheless ,I have had full support from the family for taking this endeavour forward. They travelled to Mumbai to attend my show and have always been very encouraging and supportive for all my performances. They all along with my Hospital team worked whole heartedly for my Delhi Event also.

How mandolin helps my life and profession

I don't think there is any other better relaxation. This hobby has really helped me in getting over stress which a GI surgeon faces in day to day practice. A GI Surgeon doing complicated abdominal procedures in a private sector is associated with lot of stress. Half of the time when you do an intestinal or a pancreato-biliary anastomosis in a difficult situation – you are hooked with the patient for next few days at least. That background stress always remains with you.

Playing the instrument is almost like meditation and takes away all your worries and tensions. Whenever I am tired, specially on long operating days I come back, sit on my easy chair and play mandolin for some time and close

my eyes and relax

The soothing effect of the melodies I can play now is marvellous. It gives me solace and enjoyment which is difficult to describe in words. It gives me a purpose to do something when I am free. Whenever I learn a new song & get busy with my work , I'm almost itching to reach back home and practice. When I complete the song it gives me immense happiness and joy.

Further plans

I plan to continue playing Mandolin and enjoying. I wish to keep having frequent performances with my group at various places. Also I have a "Colorectal Cancer Research Foundation" which works to increase awareness about GI and colorectal cancer. I can use this to raise funds for doing welfare and awareness activities for GI and colorectal cancer patients. Also I plan to use this music therapy for my patients. Looking at the literature I plan to make albums along with Sir for encouraging and supporting these patients with Cancer.

We can make albums for various themes: reducing anxiety and pain, improving mood and well being, encouraging to fight the disease.

Most important thing I consider is that there is some purpose in my life. I think playing Mandolin and doing charity for GI and Colorectal cancer patients gives me a sense of purpose even when I consider to retire from active practice.

Whenever I am tired, specially on long operating days I come back, sit on my easy chair and play mandolin for some time and close my eyes and relax

What I have learnt from this hobby is that Surgeons or high pressure professionals should definitely indulge in some hobbies like this. One should start early with these things as learning is better. I have tried to follow this as my son is a Guitar player, My daughter is a Bharatnatyam Dancer and they picked on these hobbies as kids .

You should persist with learning the basics even if it is sometimes boring. You will be able to play the songs better if you have the basics. This in fact is true to any skill learning.

Making new friends of different professions with common music interest gives you a different dimens

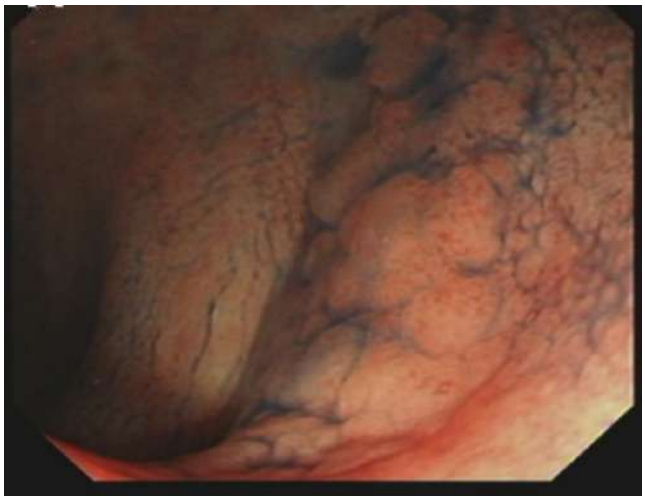
Also strengthening my fingers and finer movements help me in minimal access surgery specially laparoscopic and Robotic Surgery.

Family members often get disturbed when you keep playing these instruments and you start hearing comments initially jokingly and then .....So I often practice early morning or late night. I close the room and all the windows creating a soundproof space for playing and recording. Nonetheless ,I have had full support from the family for taking this endeavour forward. They travelled to Mumbai to attend my show and have always been very encouraging and supportive for all my performances. They all along with my Hospital team worked whole heartedly for my Delhi Event also.

Dr. Deepak Govil
Surgical Gastroenterologist
Apollo Hospitals Indraprastha,
New Delhi.

"SUTRA" QUIZ

Question 1: A 34-year-old male with pancolonic ulcerative colitis for 15 years undergoes an annual surveillance colonoscopy. Biopsies reveal indefinite dysplasia in the descending colon. Chromoendoscopy shows a 2 cm non-polypoid lesion with Kudo pit pattern V, but margins are well-defined, and the lesion is endoscopically resected completely. What is the most appropriate next step?



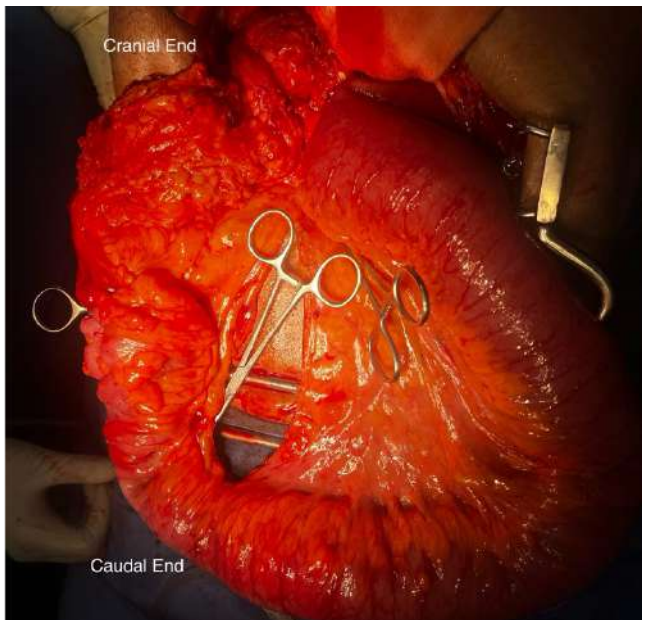
A. Continue annual surveillance colonoscopy

B. Repeat colonoscopy in 3–6 months to reassess the area

C. Recommend total proctocolectomy

D. Perform segmental resection of the affected area

Question 2: During ileocolic resection for a fibrotic terminal ileal stricture in a 40-year-old female with Crohn's disease, you observe the following intraoperative findings: creeping fat extending over the antimesenteric border, mesenteric thickening with fibrofatty proliferation, and dilated lymphatic channels. The diseased segment is resected with grossly uninvolved margins, but the mesentery is not extensively excised. Histopathology reveals transmural inflammation, fissuring ulcers, focal granulomas, and myenteric plexitis, all of which are proximal to the margin. Which of the following histopathologic or operative findings best correlates with increased risk of postoperative recurrence in Crohn's disease?



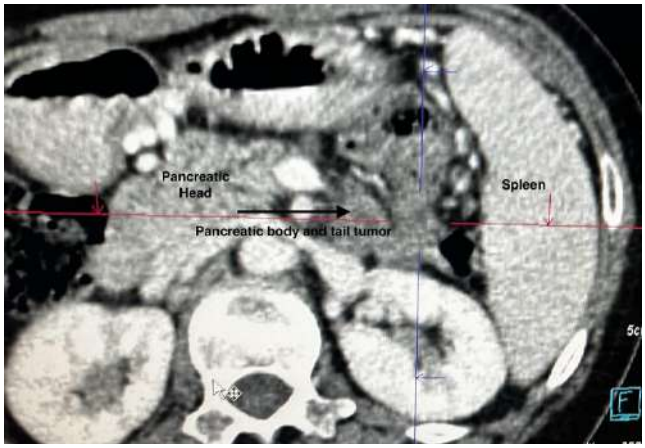
A. Transmural inflammation in the resected segment

B. Presence of non-caseating granulomas

C. Myenteric plexitis at the proximal resection margin

D. Macroscopic mesenteric creeping fat without resection of associated mesentery

Question 3: A 62-year-old woman is diagnosed with resectable distal pancreatic ductal adenocarcinoma (PDAC). Staging CT scan reveals a 2.8 cm mass in the pancreatic body and tail, without vascular involvement or distant metastases. Her CA 19-9 is elevated at 1400 U/mL. She has a BMI of 33 kg/m², ECOG performance status 2 and type 2 diabetes mellitus (HbA1c 9.1%). What is the most appropriate next step in management?



A. Proceed directly to surgery

B. Start neoadjuvant chemotherapy

C. Defer surgery due to poor performance status

D. Repeat CA 19-9 in one week

Question 4: A 58-year-old man with a history of chronic hepatitis B presents to the emergency department with sudden-onset abdominal pain, hypotension, and a tense, distended abdomen. FAST (Focused Assessment with Sonography for Trauma) shows free intraperitoneal fluid, and CT reveals a heterogeneous hepatic mass with signs of active contrast extravasation into the peritoneal cavity. Which of the following primary tumors is most commonly associated with spontaneous rupture leading to hemoperitoneum?

A. Gastric gastrointestinal stromal tumor (GIST)

B. Colonic adenocarcinoma

C. Hepatocellular carcinoma

D. Intrahepatic cholangiocarcinoma

Question 5: A 55-year-old man with a history of chronic alcohol use presents with severe epigastric pain radiating to the back, ongoing for 48 hours. He is febrile (38.4°C), tachycardic (HR 110 bpm), and has mild hypotension (BP 95/60 mmHg). Abdominal tenderness is noted without guarding. Lab tests show:

Serum lipase: 1800 U/L (elevated)

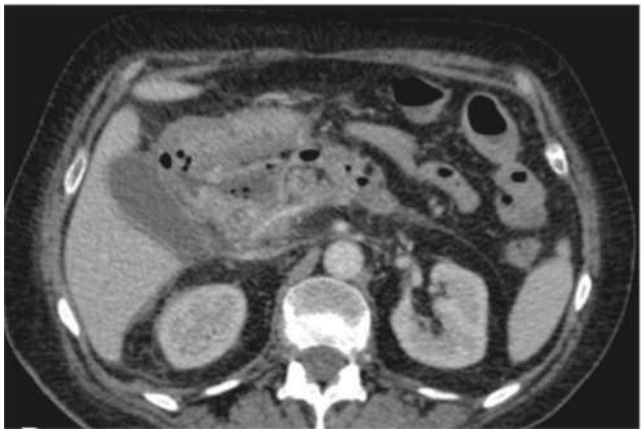
WBC count: 17,000/mm³

CRP: 185 mg/L

Creatinine: 1.6 mg/dL

Contrast-enhanced CT reveals: Necrotizing pancreatitis involving ~35% of the gland. No fluid collections or signs of gas within necrotic areas

He is currently on IV fluids, analgesics, and supportive care in a monitored setting.



What is the most appropriate next step in management?

A. Initiate empiric broad-spectrum antibiotics

B. Plan necrosectomy within 48 hours

C. Continue supportive care and monitor for clinical deterioration

D. Insert image-guided percutaneous catheter drainage

Dr. Deeksha Kapoor
DNB General Surgery,
DNB Surgical Gastroenterology
New Delhi.

Please find the answers on the last page

HAPPENINGS

IASG MID-TERM SCIENTIFIC CONFERENCE – 2025

Theme: HPB Cancer Management

Venue: SKIMS Auditorium, Srinagar

Dates: 12th–13th April 2025

A GATHERING OF SURGICAL EXCELLENCE

The Indian Association of Surgical Gastroenterology (IASG) hosted its Scientific Mid-Term Conference on Diseases of the Pancreas at SKIMS, Srinagar, drawing an impressive cohort of experts from India's most prestigious medical institutions—SGPGI, AIIMS, TATA Memorial, KEM Mumbai, PGI Chandigarh and other centres of eminence.

From state-of-the-art liver resections to complex pancreaticoduodenectomies, the conference saw a wide spectrum of clinical updates, panel discussions, and debates aimed at refining HPB cancer management strategies in India.

Notable speakers included Prof. Subhash Gupta, Prof. Sujoy Pal, Prof. Sanjay Govil, Prof. H. Ramesh, Prof. Viniyendra Pamecha, Prof. Mahesh Goel, Prof. Peush Sahni, and Dr. Sonal Asthana,

each sharing insights from years of clinical and academic excellence.

Keynote Talks

These were conducted by emeritus Professors like

Prof RA Sastri - Balancing perfection in surgery.

Prof Subhash Gupta - Liver Transplant in India – From Inception to Present

Prof. Avinash Supe- Teaching and Training in HPB Cancer.

Prof. Peush Sahni- Ethics in Surgical Practice

WOMEN LEADING THE WAY IN HPB SURGERY

This year's conference was particularly notable for its strong female representation, both in leadership and scholarship. The Organizing Secretary, Prof. Sadaf Ali, led the event with distinguished grace and academic rigor.

Prominent women surgeons and researchers who shared their expertise included: Prof. Anu Behari,Dr. Shraddha Patkar,Prof. Dr Supriya,Dr. Jaya Agarwal, Dr. Shagun Misra, Dr. Shruthi, Dr. Sumana K. Ramachandra. Their active participation marked a shift towards greater inclusivity and recognition of women in the field of surgical gastroenterology.

EMPOWERING YOUNG MINDS

A special highlight of the conference was the platform offered to young doctors, especially from AIIMS institutions like AIIMS New Delhi, Patna, Nagpur, Jodhpur,Bhubhaneshwar, Jammu and state medical colleges, to

present their ideas, experiences, and evolving practices. Speakers like Dr. BD Patnaik, Dr. Deepanksha Dutta, Dr. Kunal Bikram Deo, Dr. Manpreet Uppal, Dr. Anushree Loyal and Dr. Mohd Younis Bhat added dynamic energy and thoughtful innovation to the proceedings.

ENLIGHTENING SESSIONS AND RICH ACADEMIC EXCHANGES

Topics covered spanned pancreatic, liver, and biliary cancers, touching on current controversies, recent advances, and best practices in surgery. Key Highlights of this scientific session included

Debates:

HCC: Resection vs Transplant – Dr. Sonal Asthana vs Dr. Shaleen Aggarwal

Minimal Invasive vs Open Pancreaticoduodenectomy – Prof. Sadaf Ali vs Dr. Kalayarasan R

Panel Discussions

Complications of Liver Resection – Dr. Sadiq Sikora & team

Indian Consensus on Gallbladder Cancer – Dr. Pradeep Rebala & panel

Post-PD Complications – Dr. H. Ramesh & experts

Video Sessions

Live demonstrations of complex procedures: Whipple's with vascular resection, DP-CAR,

Robotic Hepatectomy, Spleen-preserving distal pancreatectomy, and more, presented by Dr. Vikram Chaudhary, Dr. Mahesh Goel, Dr. Anand N Singh, Dr Dash among others.

CONCLUSION

From high-impact panels and educational lectures to vibrant video sessions, the IASG Mid-Term Conference 2025 served as a catalyst for surgical excellence, inclusive growth,

and evidencebased progress in pancreatic and HPB disease management. The organizing team led by Prof. Sadaf Ali curated an experience that was not only academically enriching but also deeply collaborative and visionary. As Prof. Sujoy Pal emphasized, "Advancement in HPB surgery lies not only in better techniques—but in shared learning, ethical practice, and mentoring the next generation."

Prof. Sadaf Ali
(HOD Surgical Gastroenterology SKIMS)
Organizing Secretary

ANSWERS TO SUTRA QUIZ

Question : 1

Correct Answer: C
Recommend total proctocolectomy

Explanation:

Indefinite dysplasia, particularly in the presence of visible lesions with Kudo V pit pattern (suggesting high-grade or invasive neoplasia), raises concern for occult multifocal dysplasia or carcinoma.

Even after complete endoscopic resection, current guidelines recommend colectomy if high-risk features are present, including:

Non-polypoid morphology

Size >1 cm

High-risk pit patterns (Kudo V)

Chronic active inflammation

The risk of synchronous and metachronous cancer remains high in such patients.

Segmental resection is contraindicated due to the field effect of UC.

References:

Laine L, Kaltenbach T, Barkun A, et al. ACG Clinical Guideline: Colorectal Cancer Screening and Surveillance. Am J Gastroenterol. 2021.

Farraye FA, et al. "AGA Technical Review on the Management of Colorectal Neoplasia in IBD." Gastroenterology. 2015; 148(4): 746–774.e1.

Question : 2

Correct Answer: C

Myenteric plexitis at the proximal resection margin

Explanation:

Crohn's disease is a transmural, segmental disease with complex interaction between mucosa and mesentery. In recent years, increasing evidence supports the mesentery as an active driver of Crohn's disease pathogenesis, not merely a passive consequence of inflammation.

Key Points:

Myenteric plexitis — lymphocytic or eosinophilic infiltration of the myenteric plexus at histologically uninvolved margins — is one of the most reliable predictors of postoperative recurrence and earlier need for escalation of therapy or reoperation.

Mesenteric creeping fat, fibrofatty proliferation, and lymphatic dilatation represent disease activity and are often contiguous with mucosal lesions. However, unless the associated mesentery is actively resected, it may contribute to recurrence.

Nevertheless, in histological terms, the presence of myenteric plexitis is a validated microscopic predictor across multiple studies.

Granulomas, although diagnostic, are present in only ~30–40% of cases and have less consistent association with recurrence.

Standard resections often spare involved mesentery, but recent surgical approaches (e.g., mesenteric-based resection) are being investigated to reduce recurrence risk

References:

Ferrante M, et al. "Prognostic value of myenteric plexitis in postoperative Crohn's disease." Gut. 2006;55(5):594–599.

Kono T, et al. "Kono-S anastomosis and the role of mesentery in recurrence." Dis Colon Rectum. 2015;58(10):1051–1057.

Chowdhury R, et al. "Surgical implications of mesenteric involvement in Crohn's disease: evolving strategies." Lancet Gastroenterol Hepatol. 2022;7(2):110–122.

Gillen CD, et al. "Fistulizing and stenosing Crohn's disease: is mesenteric excision the key?" Br J Surg.2021;108(9):1040–1048.

Question : 3

Correct Answer: B
Start neoadjuvant chemotherapy

Explanation:

Although this patient meets anatomic criteria for resectable PDAC, multiple biological and host-related risk factors indicate high-risk tumour biology and poor physiologic reserve, both of which strongly support a neoadjuvant approach:

Elevated CA 19-9 (>500 U/mL), especially when unexplained by biliary obstruction, is associated with a higher risk of occult metastatic disease, early recurrence, and poor survival even in anatomically resectable cases.

Her ECOG 2 status and obesity with uncontrolled diabetes increase the risk of postoperative complications, including infections, anastomotic leaks, and delayed recovery.

Surgery-first would mean a significant risk of non-curative resection, delayed systemic therapy, and rapid disease progression.

Systemic chemotherapy (e.g., modified FOLFIRINOX or gemcitabine/nab-paclitaxel) can help:

Treat micrometastatic disease early

Allow biologic selection (i.e., only patients who respond proceed to surgery)

Potentially downstage tumors, and improve R0 resection rates

Also allows time to optimize her diabetes and improve performance status prior to major surgery.

CA 19-9 Considerations:

CA 19-9 >500–1000 U/mL without cholestasis is associated with a high rate of occult metastasis (~50% in some studies).

In patients with high CA 19-9 but no obstruction, repeat testing rarely changes management; elevated levels reflect biologic aggressiveness rather than transient fluctuations.

References:

NCCN Guidelines for Pancreatic Adenocarcinoma, Version 2.2024 Strongly recommend neoadjuvant therapy in patients with resectable disease who have elevated CA 19-9, poor performance status, or other high-risk features.

Conroy T, et al. “FOLFIRINOX versus Gemcitabine for Metastatic Pancreatic Cancer.” NEJM. 2011;364(19):1817–1825.

Cloyd JM, et al. "Preoperative risk factors for early recurrence after pancreaticoduodenectomy for resectable pancreatic adenocarcinoma." J Surg Oncol. 2017;115(4):371–377.

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Michelakos T, et al. “CA 19-9 Level > 500 U/mL Is Associated with Increased Risk of Recurrence After Resection of Pancreatic Cancer.” Ann Surg Oncol. 2021;28(7):3711–3719.

Question : 4

Correct Answer: C

Hepatocellular carcinoma

Explanation:

Hepatocellular carcinoma (HCC) has a high propensity to undergo spontaneous rupture, leading to life-threatening hemoperitoneum.

Occurs in 3–15% of HCC cases, especially in endemic hepatitis regions.

Risk factors include:

Subcapsular tumor location

Rapid tumor growth

Tumor necrosis or vascular invasion

Underlying cirrhosis with coagulopathy

Presentation is typically sudden abdominal pain, shock, and peritonitis, mimicking visceral perforation or trauma.

Management may include transarterial embolisation (TAE) for haemorrhage control, followed by staged resection in suitable candidates.

Other Tumors:

GISTs can occasionally rupture but far less commonly cause hemoperitoneum than HCC.

Colonic adenocarcinoma and cholangiocarcinoma rarely rupture spontaneously and are not associated with hemoperitoneum in the absence of perforation or trauma.

References:

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Liu CL, et al. "Spontaneous rupture of hepatocellular carcinoma and its impact on prognosis." Br J Surg.1998;85(9):1121–1124.

Question : 4

Correct Answer: C

Continue supportive care and monitor for clinical deterioration

Explanation:

This patient has moderately severe necrotizing pancreatitis without signs of infected necrosis or sepsis. The cornerstone of early management is non-interventional supportive care, including:

Aggressive fluid resuscitation

Pain control

Nutritional support (preferably enteral if needed)

Close hemodynamic and laboratory monitoring

A. Broad-spectrum antibiotics:

Not indicated unless there is confirmed or strongly suspected infection (gas on CT or positive cultures).

Routine prophylactic antibiotics in sterile necrosis do not improve outcomes and may increase resistance.

Reference: PROPATRIA trial (NEJM, 2008) showed no benefit of prophylactic antibiotics in preventing infected necrosis.

B. Early Necrosectomy:

Surgical or endoscopic necrosectomy is not performed acutely.

Interventions are ideally delayed 3–4 weeks until necrosis becomes walled-off and the patient stabilises.

Early necrosectomy is associated with higher morbidity and mortality.

D. Percutaneous drainage:

Indicated in symptomatic infected necrosis or well-defined symptomatic collections (e.g., WOPN), preferably 4 weeks.

May need an early drainage in about 30% cases.

References:

Revised Atlanta Classification, 2012 – Management framework for interstitial vs. necrotizing pancreatitis.

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A humble request from the editors...

- **Please contribute articles, reviews, reports, happenings, events etc to 'Sutra'.**
- **Please write your opinions and suggestions about 'Sutra' to us at newsletteriasg@gmail.com**
- **Please share this newsletter with your doctor friends**
- **Please register for IASGCON 2025 if you have not done already**
- **Please make your colleagues / trainees to register as well.**

BETWEEN ROUNDS

Aim for the Everest...

(to the brand-new NEET-SS PGs)

Every one of us would have crossed crossroads in our careers where difficult decisions were made. And subsequently struggled hard to justify our decisions. Announcement of NEET SS results every year is one such situation which brings many bright youngsters to this crossroads. Now a days this situation is like 'swayamvar', an event where you need to choose a bride groom from a huge congregation of menfolk. Many brides, I am sure will not be convinced about their choice and must be wondering that they could have chosen a better man and may live with this predicament all their life unhappily.

Presently, the choice of superspeciality is not the only concern. The institution, its geographic location, the case load, the level of toxicity in the unit etc. are also of concern. Just about 30 years ago when only a handful of institutions were offering these SS courses, just getting a seat was the only concern. Presently, more the choices of specialities as well as centres put everyone in a bigger dilemma.

When I was at one such crossroads in an era where there was no social media where someone can ask for career guidance and I had to choose between surgical gastroenterology and urology, a senior friend in Delhi (I was in AIIMS Delhi that time and had just joined MCh Urology) told me "See! There are 22 urologists in Chennai and very few surgical gastroenterologists and it will be easy to get a job as well as patients. Pack up and head to Chennai. I listened to that advice."

How will I mark myself at this juncture as far as my career is concerned out of 10. Maybe be 4/10 with some difficulty. (Shall tell the reasons in due course of time. I had never regretted leaving urology till I met a 'complete urologist' about a decade ago and since then that urologist and myself became great friends.

More about that 'urologist' now. He is fantastic in endourology and his TURP is a treat to watch. His usage of 'lasers' is like child's play. I was amazed at the ease with which he pulverized stones in the renal pelvis without even shedding an RBC. His ultrasound guided puncturing of the renal pelvis in whichever angle the patient is in a jiffy makes one's jaw drop. I had the good fortune of scrubbing with him a handful of times and his open surgery expertise is amazing. Performing a 'radical cystectomy' and reconstruction is like child's play to him. His 'laparoscopic surgery' dexterity and finesse is the best I have ever seen in any laparoscopic surgery till now. The way he does partial nephrectomy and PUJ reconstruction is in pure copybook style. Not even one movement is out of sync. We trained in 'robotic surgery' together and he has gone

far ahead in robotic surgery in urology. Now his forte is 'Renal Transplantation'. He does a transplant a day and often 2-3 in a 24-hour period with excellent results. He is soft spoken and down to earth. Never seen him eyeball someone or utter a harsh word in the operation theatre. I have never seen him getting another colleague urologist for difficult surgeries. He is the 'rescue surgeon' for many. And for him I give a 10/10. He is not a great public speaker nor has published much. These can be his only drawbacks so to say. He has no time for socializing or spending time on the social media.

I write all this to make the new SS trainees to understood hat should they aim for. Everyone can be a urologist, but very few can be as accomplished as my 'friend' is. We can never acquire this vast knowledge and ability by working just in one institution and one mentor. This whole training is a long drawn one under many mentors. And it takes more than a decade of training before one can call himself a urologist and apply for a position in either the public or private sector. And it is not just possible to acquire all these abilities from a single centre in 3 years. Please take up whichever degree you get MCh or DNB and in whichever centre. The centre and its faculty are not the ones who matter. Its you and your passion, your communication, dedication and your body language that matters. The choosier you are the more likely that you will get disappointed and that will show in your progress in your career. Please aim for all that my 'urologist' friend has achieved and follow his footsteps. You should thank your stars and dedication for having qualified for NEET-SS and prove to everyone around that you are 100% worth it. Do not ever think of how much money you'll make after you complete your SS degree. There is a long way to go. If you are really worth it, you'll make it big. Otherwise, it will be the story of 'also ran'. And there are hundreds of examples in each specialty presently. Have clear aims and chase them for however long it takes. There's no point to be half baked or half qualified.

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UPCOMING EVENTS

Sr No	Date	Conference	Venue
1	12th To 13th July 2025	8th annual GI cancer review	Mumbai
2	15th To 17th August 2025	IHPBA India Malaysia Singapore meet	Singapore
3	23rd To 24th August 2025	Best of ASCO India	Bengaluru
4	23rd To 24th August 2025	IHPBA Mid Term meet	Delhi
5	10th To 12th September 2025	ESCP Tripartite colorectal meeting	Paris
6	12th To 14th September 2025	2nd GIOS conference	Kochi
7	10th To 12th October 2025	35th National Conference of IASG	Chennai
8	15th To 17th October 2025	44th Congress of the European Society of Surgical Oncology	Gothenburg
9	16th To 19th October 2025	Indian Association of Surgical Oncology National Conference - 38th IASO NATCON	Goa
10	22nd to 25th October 2025	6th Congress of International Advanced HBP Surgery	Toronto
11	28th to 31st October 2025	The 10th Biennial Congress of The Asian-Pacific Hepato-Pancreato-Biliary Association 2025	Bangkok
12	20th to 22nd November2025	Oncosurg	Mumbai

35 th National Conference of Indian association of Surgical Gastro enterology

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