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Attachment with Professor Sehouli, Department of Gynaecology and Gynaecological Oncology, Charite Hospital, Berlin, Germany.

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I had the pleasure of spending three week in the department of Professor Sehouli, who is a renowned academic surgeon. His work covers both benign and malignant conditions. He is supported by a very dynamic team.

The attachment yielded multiple benefits:

- Exposure to new techniques, which I have been able to introduce to my home department such as total peritonectomy.
- An interesting appraisal of translational research and trial management.
- The opportunity to network and establish relationships to enable future collaborations in research.

During this attachment I was able to learn about the following:

1. Ontogenetically based radical surgery for cervical cancer.
2. Technical tips on challenging laparoscopic procedures.

Below I have outlined my surgical exposure during the attachment as an observer:

Date	Case	Operative details
4.1.17	Abdominal wall recurrence	Excision. Mesh repair. Drain placement. Iceberg only. Larger lesion preset. Will require urgent debulking before tumour mets thru mesh.
6.1.17	TLH BSO. Large left ov mass. Endometriosis.	Mass stuck to ant abdo wall. Separately resected. Mass placed in a bag and retrieved thru the vagina.
9.1.17	Recurrence of low grade ov ca.	The ascending/desc colon totally mobilised. The transverse colon eased ff, by prtly freeing the meentry. SB mesentry root mobilised. Complete exposure of the pelvis and mid-abdomen. Post exenteration. End colostomy. Exposure of sacral plexus. Bilat int iliac vessels ligated. Including sup glut/inf glut and pudendal vessels. PA LND, pelvic LN dissection, bilateral segmental

		ureterectomy with right nephrectomy. Accessory right renal vessels taken. Right adrenal gland preserved. Left ureter reimplanted into the bladder, of course with a stent 5/0 monocryl suture. Bilateral prolene sutures for 'sacro-colpopexy'.
10.1.17	TLH BSO BPLND omentectomy	G3 endometrial cancer. Cervical involvement.
11.1.17	Staging laparotomy for endometriod ovarian ca.	Mobilise asc/des colon. SB mesentry mobilised. IP vessels resected to the origin (on the right, not so on the left). PA LND up to the renal vessels. IMA and an accessory vessel dissected/isolated and preserved. EVEN IF THE IMA IS INJURED, NO NEED FOR SIGMOIDECTOMY. The lumbosacral trunk should become visible in the lower part of the PA LND.
12.1.17	Lap PEL & PA LND	PA LND had to be abandoned to due poor access.
16.1.17		Case cancelled due to pt being unfit for surgery for debulking
17.1.17	PMP debulking	Enbloc total peritonectomy, splenectomy & supra-colic omentectomy (recurrent ov mucinous disease on the rectum).
18.1.17	Debulking cx ca	Lap Ant resection
18.1.17	TLH BSO BPLND PALND	Serous endo ca.
19.1.17	Placenta percreta LPT, Endo ca & nodes	Recurrent endo ca in the left ext iliac region. Lower PA na dpelvic nodes cleared.
20.1.17	PDS for ovarian cancer. Stage 3c	Enbloc dissection – total peritonectomy, TAH BSO splenectomy, omentectomy with anterior resection. Additionally GB removed + left hemicolectomy done due to lack of mobility of the bowel.
	PDS	I assisted with later stages of the procedure. Bilateral enlarged inguinal LN. About 3 cm. Abdominal approach. Just superficial to the rectus sheath dissection performed and inguinal region access over the inguinal ligament.
23.1.17	Enbloc dissection for carcinosarcoma	TAH BSO omentctomy PEL/PA LND. Peritonectomy of pelvis and mid abdomen, not upper abdomen. ****Comprehensive pelvic LND, including gluteal LNs means that pt is less likely to develop lymphedema. Because all the channels are severed, lymph will flow into the pelvis and likely drained by the mesorectal channels. If some channels are left intact then the severed channels will become occluded and sluggish drainage thru the remaining channel will eventually lead to lymphedema.
24.1.17	Primary peritoneal serous ca.	TLH BSO total colectomy, PEL/PA LND
24.1.17	Lap radical hyst (TMMR approach) with pelvic LND.	Nerve sparing rad hyst, comprehensive LND lateral to the great vessels too.

The experience was very stimulating and rewarding

During this time I was also able to attend a multi-hospital trainee/trainer away day. This was a social event aimed at team building.

I would strongly recommend this attachment to any individual who wishes to learn about radical laparoscopic surgery. Indeed it also provides an excellent opportunity to learn surgical anatomy as demonstrated during live surgery by true expert surgeons.

I would very much like to thank BSGE for the generous support, which had made this trip possible.

Yours sincerely

Mr Ras Bharathan MRCS MRCOG