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Abstracts of video session

V1

Internal spermatic vein ligation by inguinal approach in local anaesthesia. A personal technique

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The validity of this technique is based on the simple execution and on the use of local anaesthesia. The acceptance of patient is excellent because the surgical operation is outpatient and you do not need the hospitalization.
Pre-operatory screening tests are not required, even in risk-patients, because the local anaesthesia is well tolerated by everyone.
The only investigations required before the operation are a Doppler examination to check the venous reflux level and the seriousness of varicocele, and a sperm count to monitor the spermatozoa concentration and the possible improvement after the surgery.
The operation starts with injection of local anaesthetic in the watertight compartment under aponeurosis of external oblique muscle in inguinal canal. In this site, you inject 15–20 ml of long acting anaesthetic (ropivacainum) that produces a complete analgesia, as in hernioplasty, and enables the isolation of spermatic vein or veins for the following upper ligation.
A special care is devoted to anatomical structures of spermatic cord (in particular the vas deferens) to prevent complications as orchitis or ischaemic atrophy.
For the last 24 months (October 1998–2000), we treated 20 cases with this technique. The discharge has always been immediate, without any overnight.
To conclude, the operation is easy and short since, in practice, it corresponds to an Ivanissevich operation with upper ligation of spermatic vein by an inguinal approach and local anaesthesia, whereas the classical retroperitoneal approach does not enables it. This technique shows a remarkable acceptance from the patients and an excellent relation between cost and benefit.

V2

Laparoscopic approach in malfunctioning peritoneal dialysis catheter and accompanying surgical pathologies

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The causes of obstruction in peritoneal dialysis are often omental wrapping and catheter tip migration.
Diagnostic laparoscopy is applied to a 57 yr-old woman for to evaluate the cause of catheter malfunction. In our exploration, we observed the catheter tip in the subhepatic region with the omentum completely wrapped around it. Also there was an indirect inguinal hernia on the right side and a lipoma with $\approx 8 \times 6$ cm^2 in the neighbourhood of internal ring. Omentum is then set free from the catheter and fixed to the parietal peritoneum on the lateral abdominal wall. Afterwards, catheter tip is pulled down into the pelvis and fixed to the peritoneum in this region. Lipoma is totally excised. Hernioplasty is performed by means of transabdominal preperitoneal approach using prolene mesh greft. Total operation period was 2 h. There was no complication. Peritoneal dialysis is started to be made on the 10th day.
According to our experience, for the salvage of malfunctioning peritoneal dialysis catheters and treatment of the accompanying surgical pathologies at the same operation laparoscopic surgery appears to be the ideal method.

V3

PerFix plug hernioplasty improves the rate of day case procedures for inguinal hernia repair

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AIM: Literature suggests that the plug hernioplasty compares favourably with the Lichtenstein repair, having particularly short and pain-free recovery periods. The aim of this study was to analyse how the introduction of the plug technique affected the clinical practice of a single surgeon.METHODS: Plug hernioplasty replaced the Lichtenstein technique at the start of 1997. So we audited the 4-yr period 31 March 1995 to 26 March 1999. The theatre register identified patients undergoing inguinal hernia repair, and case notes provided the relevant data on methods of anaesthesia operation time and inpatient status.RESULTS: Some 346 patients underwent a total of 360 inguinal hernia repairs (116 Lichtenstein versus 244 plug repairs) of which 295 were performed for primary unilateral, 28 for bilateral and 37 for recurrent herniae. The table describes operation data for each year.

Year	Operation	General anaesthesia (%)	Local anaesthesia (%)	Mean op. time (min) (range)	Day cases (%)	Inpatients (%)
1995	36	34 (94)	2 (6)	40 (20–70)	7 (19)	29 (81)
1996	62	60 (97)	2 (3)	42 (20–100)	11 (18)	51 (82)
1997	89	65 (73)	24 (27)	35 (18–56)	37 (42)	52 (58)
1998	142	107 (75)	35 (25)	30 (10–70)	93 (66)	49 (34)
1999	31	21 (68)	10 (32)	34 (15–90)	23 (74)	8 (26)

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Throughout 1996, when the Lichtenstein technique was employed, 3% of operations were performed under local anaesthetic (LA). In 1998, however, when plug hernioplasty was the repair of choice, 25% were performed under LA, representing a significant increase, $P = 0.0003$ (χ^2 test). Of the 116 Lichtenstein procedures performed, 22 (19%) were day cases and 94 (81%) were inpatients. Some 149 (61%) of the patients undergoing plug hernioplasty were discharged the same day, and only 95 (39%) required admission. The increase in the proportion of day cases since adopting the plug technique is significant, $P < 0.0001$ (χ^2 test).CONCLUSIONS: The introduction of the plug technique into a single surgeon's practice has reduced the number of patients requiring general anaesthesia, and significantly increased the number of operations performed as day cases.

V4
Videoguided information for improved postoperative information

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Ambulatory surgery is very much about how to organize selected patients in a manner that makes it possible to work more efficiently. For that purpose, the same surgeon does the same surgical procedure 6–12 times in a row. Unless you create an atmosphere allowing the patients their privacy, they easily get the uncomfortable feeling of just being an industrial number.
Our postoperative facilities do not allow the necessary privacy for the patient to receive personal information from the surgeon. By using an external handycam videocamera connected to the arthroscopy-rack and an external microphone connected to the surgeon, the surgeon records sequences while operating. Using the patients first name and limiting the sequences to show what is wrong and what is done, it is our experience that this method improves the patient's understanding of his disease and own situation.
Judged by the comment cards, the patients appreciate this way of being accurately informed. However, it must be emphasized that these tools of modern technology do not replace the whole need for personal contact between doctor and patient in a follow-up consultation. It may be timesaving by reducing the need for long conversations, and it truly improves the quality of information. We think that this method in a few years will be a standard operation procedure for patient information and documentation, a state of the art.

V5
Information video for children who are afraid of dental treatment

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BACKGROUND: Paediatric patients are often admitted to our unit for dental treatment under general anaesthesia. These patients are usually very apprehensive about their hospital admission. Their fears can be significantly reduced with appropriate preoperative information.AIM: To produce a video aimed at preparing children for inpatient dental treatment under general anaesthesia.METHOD: The local ethics committee approved the project and written consent was obtained from the parents of 2 children, both male, aged 5 and 6 yr. The patients were treated following the usual routines of our unit and a member of the nursing staff filmed their progress.SUMMARY: At the day surgery unit, we frequently take care of children whom are afraid of dental treatment. These children and their parents may have concerns and fears that are made worse by lack of appropriate information. Therefore, we decided to produce a video about the way we take care of the children and their parents. The video runs through the whole clinical scenario starting with the dental assessment right up to the postoperative follow up call 2 days later. The film will be used as an adjunct to the information given in the preoperative visit. This video is designed to improve the level of information given to our young patients and their parents enabling them to have a more positive experience in hospital. It is also hoped to be a useful tool for non-Swedish speaking patients and children with language impairment.

V6
Prostate laser coagulation – our cheapest therapy

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Prostate laser operation with special fibres is expensive; but with Diode- or NdYAG-laser and reusable (by sterilisation) 0.6 mm bare fibres (BF) price falls down to about 1/2 Euro per operation while effectivity of tissue destruction is increased and these BF enable more techniques f.i. coagulation and laser cutting.
The instrument is robust and simple-in principle a straight guide-tube adapted to the cross-section of the BF in a small shaft, water free of bacteria (f.i. produced by Katadyn Filtration System, Switzerland), electricity and a suprapubic catheter are necessary. In ambulatory surgery only coagulation should be performed because of the low complication rate (laser cutting makes bleeding). At a grid distance of about 5 mm 200 J per treatment point are beamed at the sphincter regions and small prostate floors into the mucosal surface and 1000 J into the remaining mass with instrument setting 25–30 WcwDiode- or 40–50 WcwNdYAG. Invasive coagulation (burning the fibre slowly into the depth of tissue without J-limit) destroys more prostate but goes parallel to more fever and inflammation. The 5-yr follow up at the cases in this video shows the same results as after transurethral resection (TURP).
The same equipment can be used for all indications in transurethral surgery and laser itself (especially 50 W Diode laser without changeable parts, which work on every power source) in all surgical compartments in outpatient therapy or smaller hospitals. This video wants to show a low budget laser therapy, because number of old people is increasing everywhere and questions about costs in medicine become more urgent.