KHETARPAL HOSPITAL
Newsletter
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LETTER FROM THE DIRECTOR'S DESK

THE POWER OF DECISION

When you are a creator of your reality, you're the one who initiates and creates things. Instead of waiting for things to happen, you go ahead and begin them. When others look to someone to follow, you lead the way. You start the ball rolling instead of waiting for someone else to make it roll. You take control of situations and direct them the way you desire them to go. You become the cause of events and experiences. You have the power to move the world at will because you make decisions and follow them.

It is in the moments of decision where your destiny is shaped. Where there is no decision, there is no shaping of destiny. The experience of our life's purpose involves in the act of making decisions to do what we desire to do. The divine will is expressed through us when we choose to co-create with it. We cannot avoid our role as chooser-creators in every moment of life. To decide is to cut off. Deciding is to select one possibility to manifest while cutting of all others and shaping reality to that particular form. When you do something you've never done before, you open up new possibilities and pathways where your reality can go. Things usually continue going the way they are going until a new element is added into the range of possible future events. Your future becomes less predictable and more open for anything to happen when you step into the unpredictable while remaining less in the status quo. That is why you gain more freedom when you make more decisions to do new things that expand your world.

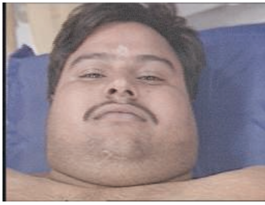
Creators don't like to wait or to rely on others to move ahead and act. They take the initiative and seek for whatever it is they desire. They are usually leaders in their field and get promoted faster than anyone else around them. They are not necessary better in term of capability but they do have one important characteristic of success, and that is the guts to take initiative. Those who do not possess this courage would follow leaders as much as the flock follows their guide. Followers never get much out of life.You wouldn't like to be around someone who always leave important decisions in your hands and try to escape responsibility. It is the manipulators who would like to guide a flock weak minded and indecisive people to their advantage. Therefore if you do not direct your own reality, others will direct it for you. The power of decision distinguishes a leader. It does not matter that his decision fails to produce the desired results. What is most important is that he takes risks and moves forward fearlessly.

To accomplish anything in life, we must be willing to take risks. A risk is a probability of things not going the way we desire them to go. Stepping into the realm of the unpredictable is the only way we can access more probabilities that we have not experienced before. When you do not put yourself in situations where there is risk involved, you shut yourself off from probabilities of your desires fulfilled. The wise way to live is to take calculated risks and act. You win by stacking the deck in your favor.

People are often afraid of making mistakes or wrong decisions because they are afraid of rejection and disapproval. That's why they would gladly have others deciding and even taking action for them. Creators are starters, action takers and decisions makers. They dare to take risks and therefore they are the ones who achieve the highest positions in their field. The rest of the population would gladly follow these starters, movers and shakers because it is safer. The price for avoiding rejection is submission.The irony is that, it is the more daring ones who are safer because they gain greater ability to handle probabilities. Those who choose to play safe by avoiding risk end up being more prone to losing because they have less ability to handle unfamiliar situations that come their way. The only way to be free from danger is to master it instead of avoiding it. Risk is only subjective according to the competency of the person facing it. Those who dare to handle risk acquire greater power and freedom in creating reality.

The power of love to change bodies is legendary, built into folklore, common sense, and everyday experience. Love moves the flesh, it pushes matter around.... Throughout history, "tender loving care" has uniformly been recognized as a valuable element in healing.
~Larry Dossey

Nature does require
Her time of preservation, which perforce
I her frail son amongst my brethren mortal
Must give my attendance to.
~William Shakespeare



PROCEDURE : LAPAROSCOPIC ADJUSTABLE GASTRIC BANDING

BARIATRIC SURGEONS (1) Dr Anil Khetarpal, MS, FAIS, FICS
(2) Dr Muffazal Lakdawala, MS

PLACE OF SURGERY : KHETARPAL HOSPITAL, NEW DELHI

TIME OF SURGERY : MAY 2007

CASE PRESENTATION

SURGICAL TECHNIQUE

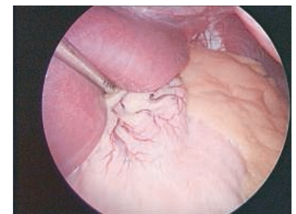
Patient Position - The patient was put in a modified Lloyd Davies' Position with the arms outstretched

Ports - A total of 5 ports were used. The 10 mm port (A),for the laparoscope, 5 mm port (B) for the left hand dissection, 10-15 mm port (C) for the right hand of the surgeon and used as band placement port, 10 mm port (D), right midclavicular, is for liver retraction and a left anterior axillary 5 mm port (E) for fundus retraction and exposure of phreno-esophageal ligament.

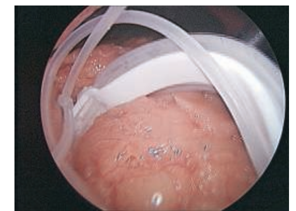
Creation Of Pneumoperitoneum - The abdomen inflated by introduction of a veress needle, creating about 15 mmHg of pressure. Careful inspection of peritoneal cavity carried out with placement of all the ports under vision

Operative Technique - In this case, we used Pars Flaccida Pathway for placing the band, as it is most prevalent in use due to the offered advantages of ease in dissection resulting in less chances of bleeding.

Step 1 - Division Of Phreno-gastric ligament - Retraction of left liver lobe upwards along with pulling downward on the gastric fundus with an atraumatic grasper results in exposure of a triangular area above gastric fundus, bounded by diaphragm, gastrosplenic ligament, esophagus in clockwise direction. In the center of this triangle, presence of phreno-gastric ligament is appreciated, it is divided carefully, which in effect exposes the angle of His and the left crus of diaphragm and causing release of fundus from the diaphragm.

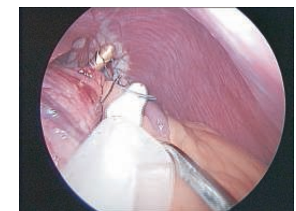


Step 2 - Exposure of the right crus - A cautious dissection of lesser omentum is carried out. As neurovascular bundle of the lesser omentum traverses lesser sac, this dissection remains a vital step. A window is made in the lesser omentum with continuation of division of lesser omentum upwards which causes exposure of right crus of diaphragm by detachment of pars flaccida.

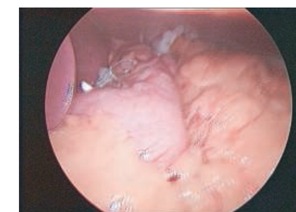


Gastric calibration tube is now introduced with decompression of the stomach. The balloon is filled with 15 cc of saline and the tube is withdrawn till a resistance is offered against gastro-oesophageal junction. The peritoneum just medial to the lower part of right crus of diaphragm incised at the point intended for placement of band. Introduction of goldfinger performed through this opening, along the left margin of the crus and directing it towards the exposed angle of His. The tip og goldfinger comes out through the opening made in the phreno-gastric ligament.

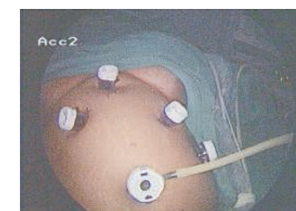
Preparation of Gastric Band prior to placement - Sterile normal saline is injected into the tubing of gastric band and subsequently withdrawn till there are no air bubbles. The fully deflated balloon grasped by pre-tied loop at the tip of the swedish gastric band with a 5 mm grasper and introduced into the peritoneal cavity through 10-15 mm left subcostal port.



Step 3 - Retro-gastric transit of the band - Re-establishement of pneumoperitoneum achieved. Loop at the tip of the band is snugged into the slit on the tip of the goldfinger, which is gently pulled through its retro-gastric path. The shoulder of the band seen coming out from behind the stomach, at the lesser curve. The balloon side of the band should face the stomach. The tip of the band is eased out through the opening pulling the band in its Position.



Step 4 - Band Fastening - As the band has been placed in the retro-gastric tunnel, gastric calibration tube is re-pushed into the stomach, balloon is inflated and the tube is pulled back till the balloon comes out of gastro-oesophageal junction. the end tags of the band are locked and the buckle is glided onto the lesser curvature of the stomach. Band can be seen secured at 45 degree from the lesser curve to the fundus of the stomach. Interrupted 2-0 ethibond, anterior gastro-gastric sutures taken to cover the band anteriorly, starting close to greater curve. 3-4 gastro-gastric sutures were required to cover the band in all aspects. The buckle of the band at lesser curvature must never be covered with sutures as it is known to predispose gastric erosion by the band. The connecting tube is then taken out by supraumbilical port. After closure of the band and with the calibration tube in place, ability of the band to rotate freely was checked. The fastening of the band should be such that a grasper can be passed under the band without difficulty.



Step 5 - Placement of Access / Injecting Port - The access port placed on the anterior rectus sheath below the sternum and for this a 5 mm transverse incision is made and exposure of rectus sheath achieved by division of the fat. A pouch formed for placement of the port. Prolene sutures passed through the holes in the ports and then through the rectus sheath and held in artery forceps. The connecting tube is mounted on the port and locked in position. The injecting port is then pushed into position and prolene sutures tied to anchor the port to rectus sheath.

Following complete reversal of pneumo-peritoneum and careful removal of all ports, skin sutured with subcuticular sutures.

Case Report

Our Patient was a 25 year old male, morbidly obese with a BMI of 45.1. He was obese since childhood but for past 4-5 years, there has been marked weight gain. He had tried various modes of treatment including life style modifications and in most of the cases, adhered to the prescribed treatment regimens, but failed to appreciate any significant weight loss. He had co-morbidities in the form of obstructive sleep apnoea, breathlessness on minimal exertion (even after slowly climbing one flight of stairs) and impotence. After meticulous history taking and careful general and systemic examination, patient was informed the need and mode of bariatric surgery required in his case. Pre Operative detailed work up done and most of the investigations were within normal limits. Pulmonary Function Test revealed Early Obstructive changes with Mild restrictive pattern.

Patient was kept on OPTIFAST diet for a week prior to the planned procedure (Laparoscopic Adjustable Gastric Banding). Patient was admitted a night before the day of surgery and Informed consent was taken. Gastric Banding was performed in general anesthesia to which patient responded well and was shifted to the ward after attainment of clinical stabilisation soon after surgery. Patient was ambulated the same evening and discharged the next morning with precise diet regimes, schedules of follow up sessions with interpretation of importance of abiding with the life style modification measures (diet, exercises etc) along with need to keep follow up session on time.

Patient was put on clear liquid diet for 1 week and liquid diet for another week. Following this, soft diet was given subsequently for 2 weeks and then normal diet was gradually started. Follow up sessions were kept at regular intervals and at 3 months post surgery, 1.5 cc of saline was put into the injection port. There were no major concerns regarding nausea and vomiting at any time during post operative period. Patient achieved weight loss of 48 Kg in 6 months post surgery and a total of 62 kg in 10 months, with BMI dropping down to 26.2 in this period. Patient was symptom free by this time and most of the pre-operative concerns were treated.

ROLE OF PATIENT SUPPORT GROUPS

At Khetarpal Hospital, we believe that patient support groups have a bigger role to play in obesity surgery than what is a general perception. Researches have unambiguosly shown that in centres where there is a good patient support group activity, obesity surgery outcomes are better, with enhanced practical approaches to cope up with the changing life styles and fewer patients are lost to follow up. A patient support group is therefore fundamentally of vital importance in achieving an individual's weight loss and health improvement goals and ensuring that the efforts made by both the patient and the bariatric core team in performing obesity surgery, is worth it.
The objectives Khetarpal Hospital sets for patient support groups are to:

* Inform and educate prospective patients and their families about all aspects of obesity surgery, (e.g. the types of surgery and the processes involved) so that they can actively participate in the surgery decision making process
* Support patients following surgery to help them to reach their weight loss and health improvement targets celebrate the successes and support each other when the going gets tough

Thus, it can be deduced that Support group activities are of pivotal importance in achieving desired results in management of a bariatric case. Patient Support Group activities help in achieving below mentioned targets.

- Create fellowship through a common bond
- Provide a source of up-to-date information about surgery and latest developments
- Educate in nutrition, exercise, and post-op needs
- Promote networking amongst the patients and health care professionals
- Increase bariatric surgery success
- Support life-style changes actively

Thus, it comes to the onus of bariatric core team of a health care center to facilitate the formation of Patient Support Groups and arrange for the related activities, with keen participation of themselves. For most of the major diseases, role of support groups is well established and it seems that in obesity this spectrum is even widened, as the involved physical, mental and social changes require long term motivation to achieve the desired outcomes.

Khetarpal Hospital...

An Emblem Of Surgical Excellence
An Insignia Of Innovations And Care

GLORIOUS NEWS

Dr Anil Khetarpal was granted 'Observership And Mini Fellowship' from Mount Sinai Medical School, Bariatric Division, Department Of Surgery, in the month of June 2008. Dr Anil Khetarpal observed various modes of bariatric surgery (Laparoscopic Adjustable Gastric Banding, Gastric Bypass, Gastric Sleeve Resection) under auspices of Internationally reclaimed Bariatric Surgeon, Dr Daniel Herron.

Dr Anil Khetarpal's complete profile and biography included in Marquis who's who, an authoritative platform for people who have made their marks globally.

Dr Anil Khetarpal was nominated for the post of Vice President, American Urogynecologic Society in the month of July, for which elections are in the process.

Dr Anil Khetarpal has been appointed as 'Peer Abstract Reviewer' of the monthly journal of American Urogynecologic Society.

SHORT HISTORY OF BARIATRIC SURGERY

DeWind, which connected the upper small intestine to the colon, followed this Jejuno-ileal bypass. Patients experienced uncontrollable diarrhea, and the procedure was converted to end-to-end anastomosis to alleviate symptoms. Modifications to the procedure included the 1973 Scott, Dean technique of bypassing smaller lengths of small intestine.

Gastric bypass was developed in 1966, by Dr. Edward E. Mason of the University of Iowa. He used surgical staples to create a partition across the upper stomach, which led to fewer complications than the intestinal bypass. The procedure involves a stapled stomach and a bypassed small intestine. Complications included anastomotic leaks, peritonitis, outlet stenosis, anemia and vitamin deficiencies. A later improvement, the Roux-en-Y Gastric Bypass, proved technically difficult to perform but led to long-term sustained weight loss.

Nonadjustable gastric banding was first introduced in 1978 by Wilkinson, who applied a 2 cm Marlex mesh round the upper part of the stomach and separated the stomach into a small upper pouch and the rest of the stomach. Eventual pouch dilatation resulted in unsatisfactory weight loss.

In 1980, Molina described the gastric segmentation procedure, in which a Dacron vascular graft was placed around the upper stomach. The gastric pouch was smaller than Wilkinson's procedure. Because the Dacron graft produced adherence of the liver to the band, it was replaced ultimately by PTFE.

In 1983, Kuzmak began using a 1 cm Silicone band to encircle the stomach, creating a 13 mm stoma and a 30-50 mL proximal gastric pouch. This band was later modified to provide adjustability of the band diameter using an inflatable balloon While it is a relatively easy surgical procedure, long-term success depends on having a high degree of patient compliance.

In 1996, Scopinaro, Gianetta et al developed Bilio-pancreatic Diversion, a limited gastroectomy with long limb Roux-en-Y and a short common alimentary canal. This procedure produces significant malabsorption and good results.

UPCOMING EVENTS

8th Obesity Patients' Support Group Meeting In July 2008
Launch Of Webportal www.anilkhetarpal.com in July 2008
CME on various Clinical and Para Clinical topics every Saturday
Minimal Invasive Surgery Week to be organized in August 2008
Free Health Screening Camp for School Children in August 2008
5th Bariatric Conference to be organized in August 2008
Cosmetic Surgery Camp to be organized in First Week of September 2008

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KHETARPAL HOSPITAL

Multi Disciplinary Super Specialty Hospital

Center of Excellence for all Laparoscopic, Endoscopic and Bariatric Surgeries

F-95,Bali Nagar,Najafgarh Road,New Delhi

An emblem of excellence, driven by ethical values infused with competency of highest standards to impart dedicated patient care. Founded in 1992 with a vision to provide world class care to everyone, Khetarpal Hospital has continually escalated its stature by adapting and innovating newer technologies and adding dimensions to absolute patient care with inimitable outcomes.

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