SUTURE

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The newly revamped SUTURE is OUT!

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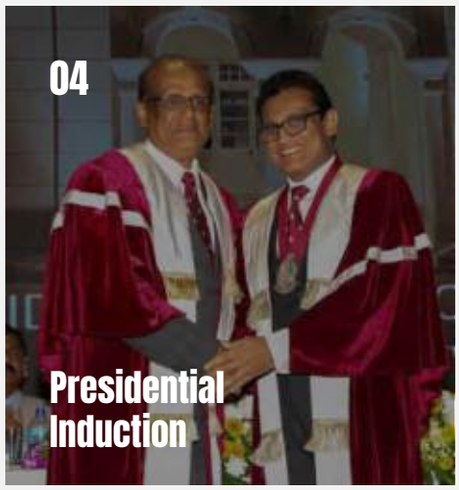
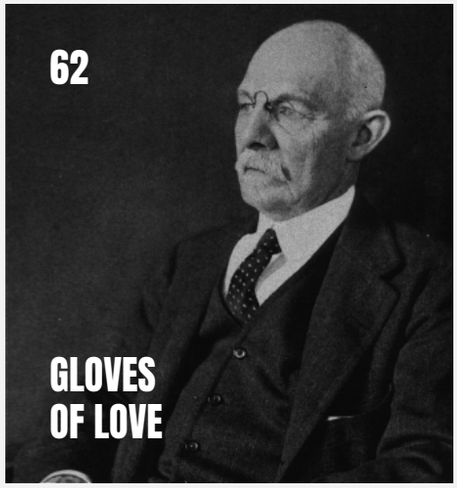
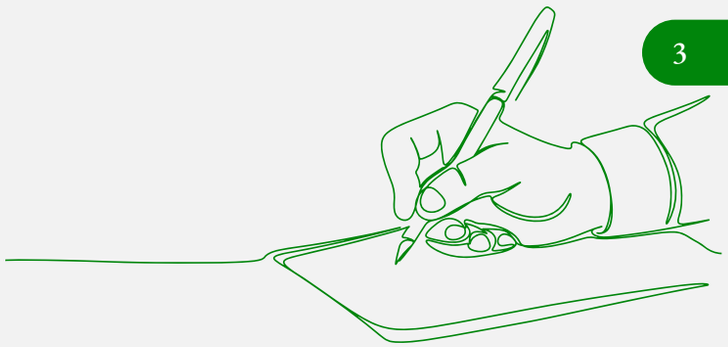




from the EDITORS



The newly revamped SUTURE is out !

Thushan, Thathya and Pramod

We are thrilled to announce the launch of our newly revamped College Newsletter, SUTURE. The SUTURE is one of our college's two regular publications, complementing the Sri Lanka Journal of Surgery. While the journal focuses on scientific and academic discourse, SUTURE serves as our newsletter and a vital platform for promoting and educating our members about the College's activities. It is also a space for sharing diverse viewpoints on the current challenges faced by our members, including peripheral surgeons and trainees.

The first SUTURE was issued in May 2002 during the leaderhip of The President at the time Dr. N Ganeshananthan and assistant secretary, Prof Aloka Pathirana. The name SUTURE exemplified the vision of the then council to bind surgeons together.

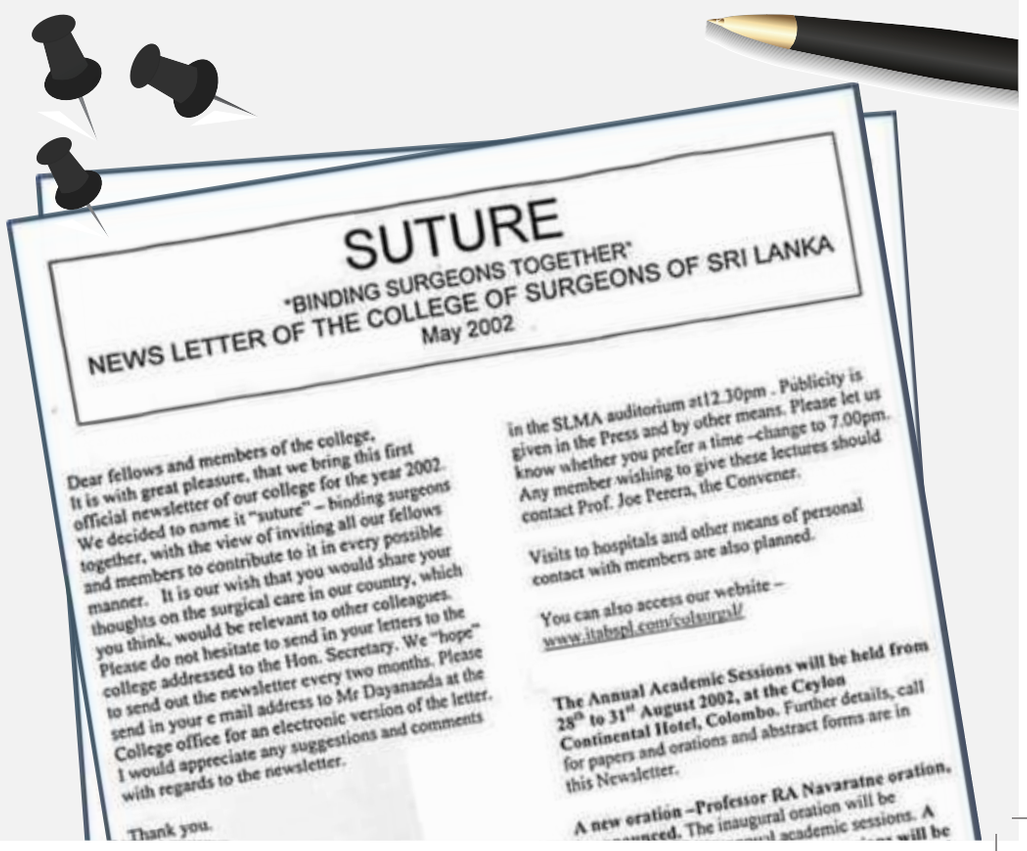
Todays' SUTURE, whilst valuing the same priniples, has evolved into becoming the voice of the college and one that promotes inclusivity, with a more vibrant view of 'Surgery in Sri Lanka' from all corners of the country and society.

A vital platform for promoting and educating our members about the College's activities.

The college has had a very busy start for the year 2025, under the leadership of Dr. Duminda Ariyaratne organizing multiple workshops spanning throughout the country, and is reflected in this edition. The Council and membership together with the Chapters of the college have contributed in a major way and have done an excellent job in bringing our surgical community together.

Preparation is also underway for the "Sri Lanka Surgical Congress 2025", the landmark event of this year's academic calendar of The College of Surgeons of Sri Lanka and it will be held from 10-13th September 2025, in Colombo.

We look forwards to you contributions for future editions of SUTURE towards making this newsletter a true reflection of our collective expertise and experiences.



SUTURE

"BINDING SURGEONS TOGETHER"

NEWS LETTER OF THE COLLEGE OF SURGEONS OF SRI LANKA

May 2002

Dear fellows and members of the college,
It is with great pleasure, that we bring this first official newsletter of our college for the year 2002. We decided to name it "suture" – binding surgeons together, with the view of inviting all our fellows and members to contribute to it in every possible manner. It is our wish that you would share your thoughts on the surgical care in our country, which you think, would be relevant to other colleagues. Please do not hesitate to send in your letters to the college addressed to the Hon. Secretary. We "hope" to send out the newsletter every two months. Please send in your e mail address to Mr Dayananda at the College office for an electronic version of the letter. I would appreciate any suggestions and comments with regards to the newsletter.

Thank you.

in the SLMA auditorium at12.30pm . Publicity is given in the Press and by other means. Please let us know whether you prefer a time –change to 7.00pm. Any member wishing to give these lectures should contact Prof. Joe Perera, the Convener.

Visits to hospitals and other means of personal contact with members are also planned.

You can also access our website –
www.itabspl.com/cslsurgsl/

The Annual Academic Sessions will be held from 28th to 31st August 2002, at the Ceylon Continental Hotel, Colombo. Further details, call for papers and orations and abstract forms are in this Newsletter.

A new oration –Professor RA Navaratne oration, announced. The inaugural oration will be

COVER STORY

The Induction of Dr. Duminda Ariyaratne as the 43rd President of the College of Surgeons of Sri Lanka was held at the Sri Lanka College of Surgeons Auditorium at Nidahas Mawatha, Colombo, on January 11. The event was graced by the presence of Chief Guest, Attorney General Parinda Ranasinghe, Guests of honor, Dr. Mahanama Gunasekara, former President of the College, and Dr. Anil Jasinghe, Secretary to the Ministry of Health and Mass Media

The outgoing President of the College, Specialist Dr. S.M. Niyas, handed over the position to the new President, Dr. Duminda Ariyaratne in a grand ceremonial occasion.

PRESIDENT'S ADDRESS

Chief guest Hon Parinda Ranasinghe (Attorney General of the Socialist Republic of Sri Lanka), Guests of honour- Dr Anil Jasinghe: Secretary of the Ministry of Health and mass media and Dr Mahanama Gunasekara, past president of the College of Surgeons of Sri Lanka, Dr S M M Niyas Immediate past president, Past Presidents, members of the council, distinguished guests, Ladies and Gentlemen.

Today marks a significant milestone in my life as I assume the presidency of the College of Surgeons of Sri Lanka. On this occasion, I wish to express my gratitude to the past presidents, fellows, and members of the College for placing their trust in me to lead this esteemed institution in 2025.

The College of Surgeons of Sri Lanka stands as the apex body representing the surgical fraternity in the country and is widely recognized by professional organizations around the globe.

The College of Surgeons of Sri Lanka was formally established in 1972 with Dr. P. R. Anthonys as its founder president. A significant milestone in the College's journey was acquiring its current headquarters in 2004. This magnificent property once belonged to Dr. Noel Bartholomeusz, an eminent surgeon of the 1960s, and his wife, Nora Bartholomeusz was generously gifted to the College. This gift was realized through the tireless efforts of Professor A. H. Sheriffdeen, the late Mrs. Anne Ranasinghe, and the late Dr. Vimala Navaratne and Professor Harsha Senevirate. We make it a point to honor them at all our important functions.

I must acknowledge the unwavering dedication, commitment, and visionary leadership of my predecessors, which have elevated the College to its current stature. I deeply appreciate the kind words of introduction by the outgoing president Dr S M M Niyas this evening. I commend his great leadership backed by his able secretary and the council for their remarkable efforts in strengthening the peripheral chapters, fostering relationships with international professional bodies, and consolidating the financial stability of the CSSL.

I am deeply honoured by the presence of all of you here this evening and extend my sincere thanks to each one of you. I

> The College of Surgeons of Sri Lanka stands as the apex body representing the surgical fraternity in the country

am particularly humbled by the presence of the Attorney General of Sri Lanka, Hon. Parinda Ranasinghe, a distinguished individual with whom I had the privilege of sharing school days.
I am also profoundly grateful to the Guest of Honor, Dr. Anil Jasinghe, who now holds the high position of Secretary to the Ministry of Health and Mass Media.

Lastly, I am deeply moved by the presence of Dr. Mahanama Gunasekara, who has been a clinical tutor, senior colleague, and a dear friend since my medical student days.

As I stand here with pride, I am mindful of the many surgical colleagues who, though present with us in spirit, are unable to join us physically due to their professional commitments. I am particularly referring to the surgeons tirelessly working around the clock in peripheral areas, often with limited resources. It is only fitting that I offer my heartfelt tribute to these dedicated professionals who provide essential surgical services across the length and breadth of this country.

I would like to take a moment to acknowledge the invaluable contributions of fellow general surgeons. My presence here today is a testament to my journey as a general surgeon. They unanimously elected me as the president of the Association of General Surgeons of Sri Lanka in 2018. My colleagues and I faced the challenge of addressing the multifaceted issues confronting general surgeons serving in remote areas.

I would like to reflect with gratitude on my journey with the College of Surgeons of Sri Lanka. Soon after completing the MS (Surgery) examination, I became a full member of the College in 2003.

Upon returning from overseas training in 2007, following a year of service in Trincomalee, I was appointed to the Accident Service of the National Hospital of Sri Lanka. There, I had the privilege of working alongside the dynamic senior surgeon Dr. Ranjith Ellawala who invited me to his council as Assistant Secretary. I eagerly accepted the offer, marking the beginning of my journey with the council, where I have proudly served ever since.

> I am deeply aware of the challenges which lie ahead of me in the coming year.

A pivotal moment in my service to the council came in 2011 when the then-president, Dr. K. L. Fernando, proposed my appointment as the Director of Overseas Training. This was a significant honor, especially as I was one of the most junior members of the council amidst highly esteemed figures in the field.

I am deeply aware of the challenges which lie ahead of me in the coming year. These include addressing surgical services of the country, issues related to training of surgeons and getting involved with the Ministry of Health in planning and implementation of health-related policies. In addition, my team should collaborate with professional bodies locally as well as internationally.

Surgical Services

The country's surgical services have been grappling recently posing numerous challenges to the Ministry. Financial instability, the mass migration of surgeons, and the loss of skilled middle-grade medical and nursing staff have emerged as pressing concerns. Peripheral units, in particular, are bearing the brunt of these issues. As we gather here today, several peripheral units have been forced to scale down their services due to a lack of general surgeons. The District General Hospitals Ampara, Monaragala, Hambanthota, Nawalapitiya, Kilinochchi, Mannar, and Mullaitivu are covered by acting surgeons. Currently, there are approximately 60 vacant slots in the annual list for the year 2025, but only less than 10 board-certified consultant general surgeons are available for appointment. 180 general surgeons in the ministry annual list in 2014- 2017, had been shrunken to 125 today. The situation in subspecialties like cardiac surgery, and pediatric surgery is much worse.

Current statistics reveal that a significant percentage of our trainees who return after overseas training subsequently migrate to developed countries in search of better opportunities. We ought to develop a mechanism to retain our newly qualified junior colleagues to serve the motherland.

To mitigate this trend, I propose offering additional allowances to surgeons working in less favourable regions, alongside providing regular time off to spend with their families. The implementation of a cluster system in peripheral hospitals which is currently being piloted in nine regions with ADB funding, offers a promising solution. The value of cluster systems in improving working conditions and service delivery cannot be overstated. We may even have to consider the re-employment of retired surgeons to serve in the vacant units until the situation improves.

The College of Surgeons of Sri Lanka assures the Ministry of Health and the newly elected government of our fullest support and cooperation in addressing these challenges and strengthening the country's surgical services.

Surgical Training

The College of Surgeons of Sri Lanka has maintained a close partnership with the Postgraduate Institute of Medicine (PGIM) since its inception, playing a pivotal role in surgical training. The PGIM and the College are essentially two sides of the same coin when it comes to shaping surgical education. Members of our College, drawn from universities and the Ministry of Health, voluntarily contribute to curriculum development, training, quality assurance, and the

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conduct of examinations.
Our training programs have earned international recognition, with the General Medical Council (GMC) of the UK now granting full registration to our postgraduate trainees, enabling them to work in the UK. Additionally, the Royal College of Physicians and Surgeons of Glasgow awards the Membership of the Royal College of Surgeons (MRCS) diploma without examination to our successful MD Surgery trainees. This recognition has significantly improved their ability to secure competitive, high-level training positions in the UK.

Despite these achievements, there is still more to be done to elevate our training to true international standards. Currently, we are revising the curriculum for postgraduate surgical training, and I pledge my full support for this initiative, not only as the President of the College but also as the Chairman of the Specialty Board in General Surgery. We also aim to empower surgeons across the country to achieve higher professional standards as trainers and to ensure that trainees receive comprehensive exposure to the full spectrum of surgical practice.

As the world advances rapidly in technology, we must ensure our training keeps pace. For instance, robotic surgery has made significant progress not only in the West but also in neighbouring countries. Unfortunately, Sri Lanka has yet to acquire a robotic surgical system. However, the College has successfully advocated to the National Medicines Regulatory Authority (NMRA) to approve the introduction of a robotic system. I am optimistic that, shortly, our trainees will have the opportunity to develop robotic surgical skills locally.

The College organizes numerous surgical courses primarily aimed at trainees, which are consistently well-attended. Our surgeons generously contribute to these events voluntarily. The laparoscopic skills laboratory, established by Dr. K. L. Fernando in the College in 2011, has been extensively utilized over the years. However, it is now time to upgrade to a state-of-the-art skills center facility to meet the evolving demands of trainees and surgeons. I have been actively involved in this initiative alongside several past presidents and remain committed to bringing this vision to fruition.

Contribution To The State

The College of Surgeons of Sri Lanka has been a key stakeholder in the national health and administrative framework of the country. We are actively represented in several critical institutions, including the National Medicines Regulatory Authority (NMRA), the National Trauma Secretariat, the Postgraduate Institute of Medicine (PGIM), and other statutory bodies. This year, we renew our commitment to supporting and advancing the initiatives of these vital institutions.

With the election of a new government, promising concepts have been introduced to enhance the healthcare delivery system, including the prospect of increased budgetary allocations for health. The College wholeheartedly assures its fullest cooperation to the Ministry of Health and the state in their efforts to strengthen and uplift the country's surgical services.

Collaboration With Other Professional Bodies

I extend my gratitude to our sister colleges, most of whom are represented here this evening. Over the years, we have collaborated on numerous initiatives aimed at educational and professional development, as well as the advancement of healthcare services. Regardless of the scale of these efforts, we remain committed to working together as a united team to achieve our shared goals in 2025.

The College of Surgeons has also cultivated strong ties with international sister colleges, including the Royal College of Surgeons of England (RCSE), Edinburgh (RCSEd), and Glasgow (RCPSG), as well as associations in the South Asian region, Malaysia, and Singapore. We aim to strengthen these collaborations further for mutual benefit, fostering shared growth and development in the coming year as well.

> Over the years, we have collaborated on numerous initiatives aimed at educational and professional development, as well as the advancement of healthcare services.

Acknowledgement

Teachers of my Alma Mater- Mahanama College where I did my primary education and then Royal College Colombo. I am honored some of my teachers and schoolmates have joined me tonight. Teachers of UCFM and clinical teachers primarily of the Ministry of Health. My undergraduate and postgraduate supervisor Dr S S Jayaratne- was my supervising consultant during the internship and initial registrar appointment. Dr Henry Rajaratnam, my medical appointment supervisor, and Dr D S Liyanarachchi who was my supervisor in the senior registrar period of training.

This evening, I would like to express my heartfelt gratitude to the medical, nursing, and allied health staff at all the hospitals where I have served as a surgeon. Starting from the General Hospital Trincomalee, Base Hospital Balapitiya, Base Hospital Horana, Colombo East Base Hospital, and the National Hospital of Sri Lanka- to my current workplace, Colombo South Teaching Hospital, I have been fortunate to receive unwavering support from my junior medical staff and the nursing colleagues right throughout who have always enabled me to perform my duties effectively.

A special note of appreciation goes to the staff of Colombo East Base Hospital, who worked alongside me without hesitation during the pandemic to provide care for COVID-infected surgical patients.

Similarly, I am deeply grateful to the dedicated staff of General Hospital Trincomalee, who not only cooperated with me but treated me with great warmth and respect as we served underprivileged civilians and military personnel from all communities with the utmost dedication.

> Starting from the General Hospital Trincomalee, Base Hospital Balapitiya, Base Hospital Horana, Colombo East Base Hospital, and the National Hospital of Sri Lanka- to my current workplace, Colombo South Teaching Hospital, I have been fortunate to receive unwavering support from my junior medical staff and the nursing colleagues right throughout who have always enabled me to perform my duties effectively.

I am deeply grateful to all my surgical colleagues who have supported me throughout my training and career as a surgeon. Over the years, they have entrusted me with various positions on the college council. I would like to especially thank my general surgery colleagues who unanimously elected me as the President of the Association of General Surgeons of Sri Lanka in 2018. I am confident that you will continue to support me as I fulfil my duties as the President of the college, just as you have done always.

I would like to express my heartfelt gratitude to my parents, late brother, sister, and their families. My mother, who is no longer with us, sacrificed her life to care for us. She instilled in her three children the values of kindness and compassion, especially towards the underprivileged. Even before I entered medical school, she often recited these principles to us, like a mantra, so they would become ingrained in us. Any concern I have for the poor and needy is undoubtedly due to her influence. My father, who is now 91 years old and present in this audience, never saved money for us. Instead, he spent it generously on our well-being. He also had a mantra, which goes "What matters is not how much you make, but how you made that much." This advice left a lasting impression on us and continues to guide me in my career.
My brother, who lived overseas for many years, tragically passed away early. I have no doubt he would be the happiest person today if he were alive. Unfortunately, his family couldn't join us today due to work commitments.
My sister, likely a professional contemporary of today's chief guest, is here with her daughters. Thank you for being a caring sister.

I would also like to extend my gratitude to my family. My wife, Ganga, has been the main pillar behind my success. As my batch mate, she has mastered the art of putting up with me—no easy task, as those who know me personally can attest. She raised our two children, Archana and Sasmitha, to be kind-hearted and good human beings. While I led a busy life, she maintained the bond with our children, guiding their education and upbringing. Though I have always provided for my family to the best of my ability, the credit for creating a perfect home belongs to her.

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Closing Remarks

Chief guest, guests of honor, past presidents, members of the council, my dear colleagues, ladies, and gentlemen,

I am deeply moved by your presence this evening, especially given that it is the start of a long weekend. The presidential induction ceremony is one of the most significant events on the college calendar. Traditionally, at this function, the president and the council unveil the theme, action plan, and strategies for the upcoming year. I eagerly anticipate a prosperous 2025, following the path set by my predecessors.

I am confident that my council and I will be guided by the rich traditions, norms, and values fostered by our surgical fraternity, both past and present. I look forward to receiving your guidance and input, as you have generously provided throughout my tenure on the council over the years.

Let us all strive diligently to deliver state-of-the-art surgical services to all needy patients across this beautiful country, regardless of differences.

Thank you very much indeed!

COUNCIL 2025

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COUNCIL 2025

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SL College of Oncologists	Dr. S Dileepa Mahaliyana
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Surgeons	Dr Nirukshan Jayaweera
Association of General Surgeons	Dr Roshan Dassanaieke
SL Orthopaedic Association	Dr Devaka Rathnapala
SL Association of Urological Surgeons	Dr Munipriya Willararachchi Association of
Plastic Surgeons	Dr Shashanka Rathnayake
Association of Paediatric Surgeons	Dr Sisil Kumara
Association of Cardiothoracic Surgeons	Dr Mahendra Munasinghe
SL Society for Vascular Surgery	Dr Amanthana Marasinghe
SL Association of Minimal Access and Digital Surgeons	Dr Rasitha Manatunga

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Northern Chapter	Dr S Gobishangar
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Eastern Chapter	Dr Buddhika Thilakarathna
Wayamba Chapter	Dr Mahinda Mallawatantri
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North Central Chapter	Dr S Srishankar
Western Chapter	Dr Wasantha Wijenayake

COLLEGE FOCUS

Malik de Soysa
Honorary Secretary | CSSL - 2025

The College of Surgeons of Sri Lanka – Yesterday, Today & Tomorrow

Established in 1971, the College of Surgeons of Sri Lanka has evolved into the nation's leading institution for surgical excellence and the guiding force for all surgical subspecialties. Advancements in various aspects of its operations have shaped its growth over the years, making it indispensable in shaping the future of surgical care in Sri Lanka.

Administrative and Advisory Role

From its modest beginnings in a small room at the Sri Lanka Medical Council, the College has now found its home at the Noel and Nora Bartholomeusz Foundation. This headquarters is more than just an administrative space—it features an auditorium, a museum, a classroom, and a skills lab, located in the heart of Colombo.

In its advisory capacity, the College plays a crucial role in shaping surgical practices nationwide. It collaborates closely with key decision-making bodies such as the Ministry of Health, the National Medicines Regulatory Authority (NMRA), and the Sri Lanka Medical Council (SLMC). Acting as a trusted consultant, the College contributes significantly to policies and strategic decisions concerning both present and future surgical care in Sri Lanka.

National and International Collaborations

The College maintains strong partnerships both locally and internationally. Within Sri Lanka, it actively coordinates academic and professional initiatives alongside sister colleges and organizations such as the Sri Lanka Medical Association. Globally, it collaborates with prestigious institutions, including the Royal College of Surgeons of England, the Royal College of Physicians and Surgeons of Glasgow, and the Royal College of Surgeons of Edinburgh.

Additionally, under the umbrella of the South Asian Surgical Care Society—headquartered in Sri Lanka—the College fosters knowledge-sharing and professional networking across the region. Such affiliations not only enhance global ties but also facilitate foreign training opportunities for Sri Lankan trainees, enabling them to compete on an international platform with credentials that elevate their standing in the surgical community.

Training and Professional Development

The College is committed to nurturing the next generation of surgeons by offering a diverse range of training programs designed to keep professionals updated with the latest advancements in the field. These programs, conducted at regular intervals, include SETS, OTST, SHO Training, SURGE AHEAD, ESSP, ESTC, ATLS, DMMT, NTMC, Basic Laparoscopic Training, ITCN, Pre-Intern Training, and GP Training.
Furthermore, the College supports candidates preparing for surgery-related examinations such as the Common Selection Examination, the ERPM examination, and the MRCS Preparatory Course for the MRCS examination. The dedication of numerous individuals who oversee these programs is invaluable, and their contributions are deeply appreciated.

Governance and Structural Organization

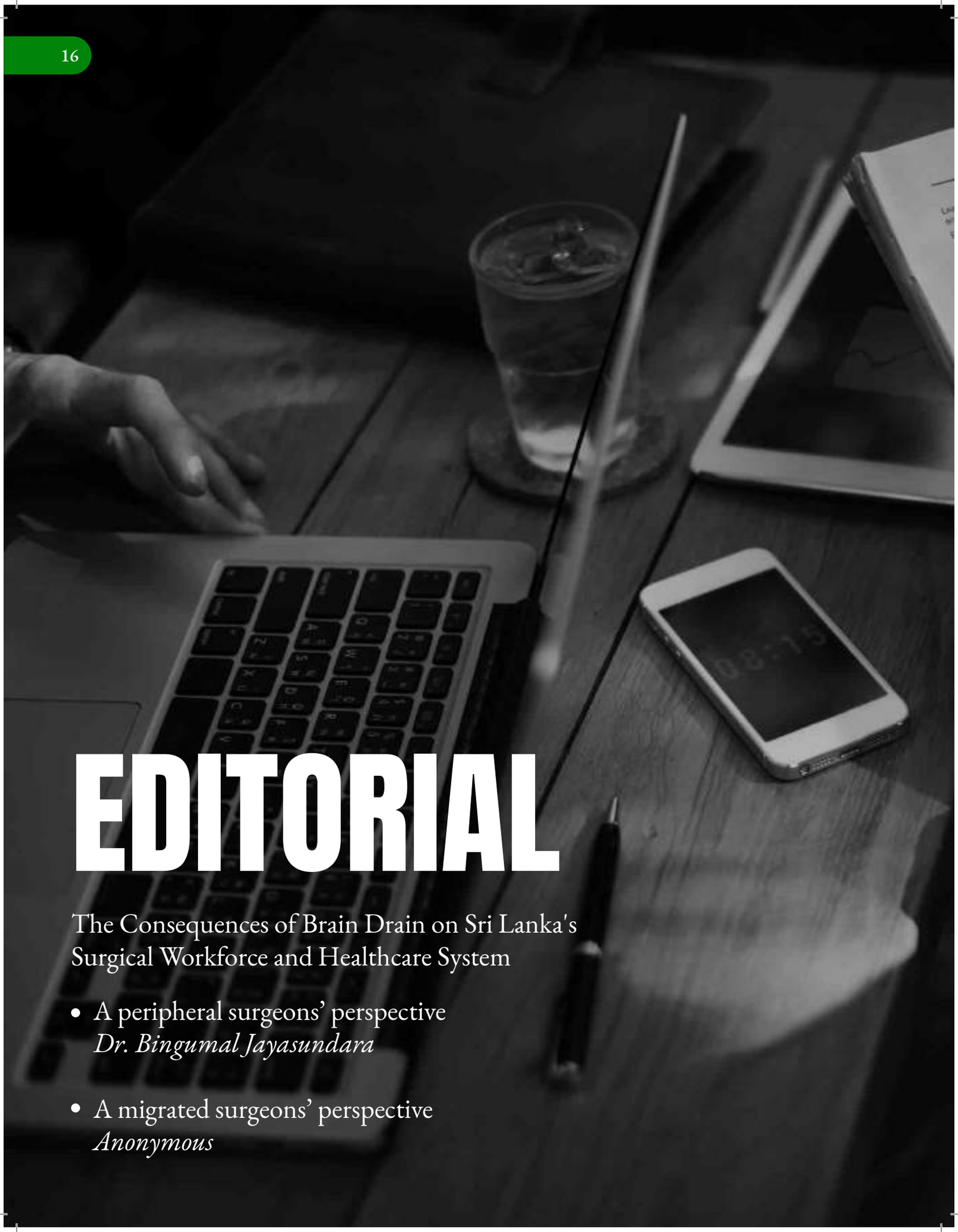
To ensure efficiency in its operations, the College relies on its eleven subcommittees, each tasked with specific responsibilities. These subcommittees address various aspects, including academic and research, membership and fellowship, finance, professionalism and ethics, publications, web and IT, networking and hall hiring, international affairs, examinations, surgical instruments and consumables, trauma, and property and asset management. Their collective expertise ensures informed decision-making and a streamlined approach to advancing the College's mission.

The Pinnacle Event: Sri Lanka Surgical Congress

Among its many initiatives, the Sri Lanka Surgical Congress stands as the College's most prestigious event, bringing together professionals and leaders from around the globe. This year, the congress returns to Colombo from September 10th to 13th, dedicated to the theme: "Empowering the Future Surgeon in the Service of Humanity." The congress promises to showcase the latest innovations and updates in surgical care, making it an essential gathering for professionals seeking to expand their knowledge and expertise.

Recent Milestones and Ongoing Challenges

The College has already achieved significant milestones in 2025, including the successful conclusion of its Annual General Meeting on March 28th and the signing of a Memorandum of Cooperation with the Royal College of Surgeons of England on April 26th.
Despite its successes, the College faces challenges, particularly in maintaining the momentum of its ongoing activities. Communication lapses and short-notice meetings with the Ministry of Health often create logistical difficulties. Additionally, many board-certified surgeons have yet to obtain College membership, highlighting the need for greater engagement. Efforts must be made to educate budding surgeons about the rich traditions of the College, ensuring they uphold its legacy and contribute to the future of surgical excellence in Sri Lanka.



EDITORIAL

The Consequences of Brain Drain on Sri Lanka's Surgical Workforce and Healthcare System

- A peripheral surgeons' perspective
  Dr. Bingumal Jayasundara

- A migrated surgeons' perspective
  Anonymous


BUSINESS
Economy of the European Union
World Bank's stock at all-time high

SRI LANKA'S SURGICAL BRAIN DRAIN: A LOOMING CRISIS

Editorial Board, College of Surgeons of Sri Lanka

The editorial team appreciates the contribution of Dr. Mahanama Gunasekara, Consultant Surgeon - NHSL and Past President of CSSL, as well as Dr. Wasula Rathnaweera, Consultant General Surgeon – Base Hospital Karawanella, toward this editorial.

Sri Lanka's health education system has long been a point of pride, producing highly skilled surgeons who serve locally and internationally. However, in recent years, a growing number of experienced surgeons and promising trainees have been leaving the country, seeking opportunities abroad. This trend raises critical questions about the sustainability of surgical services in Sri Lanka and demands urgent attention from policymakers, hospital administrators, and the medical community.

The Crisis

The brain drain disproportionately affects young consultants, particularly those freshly trained abroad, and its impact is most acutely felt in peripheral general surgical units. Junior surgeons traditionally begin their careers in regional hospitals, but as fewer choose to stay, many units are being abandoned. The resulting vacancies in major centers (Colombo, Kandy, Galle) draw remaining talent away, leaving rural patients with diminished access to care.

The departure of newly trained consultants also creates a vacuum in advanced surgical techniques, such as minimally invasive surgery and novel treatment strategies. Many peripheral hospitals already lag in exposure to these innovations, widening the gap between Sri Lankan surgical care and global standards.

Even in tertiary care centers, specialists in fields like colorectal, hepatobiliary, and plastic surgery are migrating, compounding the strain on the system. This triggers a domino effect: complex cases overwhelm remaining specialists, while understaffed peripheral units force

Statistics

- More than 1,800 doctors have left the country in 2022 and 2023
- Nearly 400 specialists have left in the past two years
- Nearly 5,000 Sri Lankan doctors have completed the exams required to leave the country,
- The 180 general surgeons on the Health Ministry's annual list in 2014-2017, have decreased to 125 today.
- Only 10 board-certified general surgeons are available to fill around 60 vacant slots in the Annual Transfer List of 2025.
- Ampara, Moneragala, Hambantota, Nawalapitiya, Kilinochchi, Mannar and Mullaitivu District General Hospitals are covered by acting surgeons.
- Salaries abroad are nearly 20-30 fold higher
- Sub-specialties like cardiac, paediatric and plastic surgery are most affected
- No formal tracking system exists—Postgraduate Institute of Medicine (PGIM) issues documents for migration but does not record them.

The Ripple Effects: Beyond the Operating Room

The loss of skilled surgeons has immediate and long-term consequences beyond the obvious.

As two-person stations shrink to one and spoke hospitals remain unmanned, remaining surgeons face crushing workloads leading to burnout & administrative overload. Many juggle clinical duties, administrative tasks (due to medical officer shortages), and emergency calls, leading to exhaustion and declining care quality.

The exodus of surgeons is not just depleting the healthcare workforce—it is also eroding the foundation of medical education in Sri Lanka. With surgeons leaving, junior trainees in peripheral hospitals lack mentors, forcing some to abandon surgical training altogether. Without hands-on guidance, skill development stagnates, weakening the next generation of surgeons. Undergraduate teaching too suffers as faculty surgeons in universities and extended teaching hospitals are stretched thin by clinical workloads, administrative burdens, and migration trends.

The impact of surgical brain drain is felt more in the state hospitals, and as state hospitals struggle, patients turn to private institutions, deepening healthcare inequality. Another less obvious but real impact is a societal impact. Many of those who migrate leave behind elderly parents dependent on colleagues. A change in patient demographics is becoming more and more obvious.

> Without hands-on guidance, skill development stagnates, weakening the next generation of surgeons.

Is this current migration just another repetition of the cycle?

The current wave of medical professionals leaving the country differs significantly from past migration trends during the 1971 insurgency and the civil wars in the 1980s - 2000s. In the past, doctors left primarily due to fear of violence and conflict, whereas today's exodus is driven by economic collapse and low salaries.

Unlike previous decades, when mostly general practitioners emigrated, specialists like general surgeons and sub-specialists are departing in alarming numbers. While hundreds left annually in the past, over 1,800 doctors have migrated in just the last two years, with another 5,000 preparing to leave. Additionally, many who left during wartime returned after the conflict ended, unlikely to come back due to permanent migration pathways.

> Countries like the UK and Australia are aggressively recruiting with fast-track visas...

This crisis is far more severe for several reasons: specialists are much harder to replace than general doctors, and there is no post-war recovery in sight—instead, the economic crisis could persist for years.

Countries like the UK and Australia are aggressively recruiting with fast-track visas, intensifying global competition for skilled medical professionals. Unlike past shortages, which were patchy and manageable, today's situation risks a complete systemic collapse, as the government, now financially strained, lacks the funds to offer competitive salaries.

Is There a Silver Lining to Surgeon Migration?

The brain drain of Sri Lankan surgeons poses severe challenges, but it is unavoidable and has already happened. The exodus seems to have plateaued, but will continue. Can we strategically manage the situation toward achieving some potential long-term advantages?

The college and its societies can maintain ties with migrant surgeons by facilitating international collaborations, training exchanges, and research partnerships. Especially countries like India and the Philippines have diaspora engagement programs to formalize knowledge-sharing and strengthen global networks. The college currently collaborates with international chapters, particularly in the UK and Australia. We could enhance the activities of these existing international chapters and promote new overseas clusters.

> Sri Lanka could encourage temporary or circular migration...

The crisis has forced policymakers to acknowledge decades of neglect in healthcare infrastructure and workforce planning. This presents an opportunity to pressure the Ministry of Health and other stakeholders for systemic reforms, including revising the healthcare delivery model and task-shifting (e.g., training non-surgeon clinicians for basic procedures to fill gaps).

Instead of a one-way "brain drain," Sri Lanka could encourage temporary or circular migration, where surgeons work abroad for a few years before returning with enhanced skills. A brain circulation model.

However, the caveat remains that any benefits are not automatic unless proactive measures are taken.

Possible Solutions to Retain Surgeons

A system and policy reform is crucial, and the College needs to be at the forefront of guiding the Ministry of Health to reverse this trend.

The college can play a pivotal role in planning short-term and long-term strategies to mend the gaps in surgical services created by the current economic catastrophe. The current trade war between the global financial hubs would enforce further pressure on our volatile economy.

Adjusting pay scales to offer competitive salaries and incentives and streamlining MoH functioning to reduce bureaucratic delays would encourage surgeons to stay. However, given Sri Lanka's economic limitations and nightmare red tape on policy reforms, expecting meaningful salary hikes or large-scale infrastructure investment is not immediately feasible. Can the system be adjusted to compensate the surgeons and the medical officers working in the periphery? Be it via financial remuneration or additional leave?

Yet, there are nonfinancial and systemic interventions to help retain surgeons and stabilize the service with the existing workforce. Restructuring specialist vacancies based on resource availability, population densities, and transport challenges can be implemented with immediate effect, as the statistics needed for such changes are already available in the MOH.

Everyone has a right to migrate, however, those who are leaving the country after higher education at the expense of public funds must adequately and fairly compensate for the investment of the government. Funds generated by such compensations could be allocated to improve the postgraduate continued medical education of doctors remaining in the country.

> Surgeons, too, are human beings with responsibilities towards families and partners. Can the system understand the human requirements and introduce flexible work models

A significant percentage of funds available for emergency surgical care is consumed by victims of Motor Vehicle Accidents. Accounting for the cost of the care for them could be implemented early, and new legislation could be introduced to recover such costs from vehicle insurance companies.

These are a few proposals to make health reforms financially viable and sustainable until more permanent measures are introduced. "Everyone has a right to access affordable and safe health care, however, the burden of health care also should be shared by everyone equitably".

We can also expand the role of the available nonconsultant surgical workforce (e.g., medical officers, surgical trainees, resident house officers) in pre- and post-operative care or minor surgeries and allow surgeons to focus on complex procedures. Intermediate carder proposals, currently being discussed, are a good forum to introduce measures to harvest the surgical skills of non-specialist medical officers.

Utilizing retired surgeons as part-time consultants for mentoring and elective procedures can be considered. Their expertise can also be put to use in the skills development of intermediate carders and deployment in government healthcare projects outside the mainstream health services.

Safeguarding junior consultants in the peripheries is crucial to ensuring a national service. A mechanism can be introduced to pair more experienced consultants with trainees in peripheral hospitals towards a national surgical mentorship program to prevent isolation attrition.

Reinforcement of regional surgical hub and spoke models could create opportunities for trainees to rotate for exposure to advanced procedures and skill transfer.

For most surgeons, a fast solution is required to improve work-life balance and reduce burnout. Hospital management staff should be delegated to perform non-clinical tasks, freeing surgeons from clinical duties. Emergency call burdens may have to be shared more equitably by implementing structured duty rotations. Surgeons currently not getting involved in emergency care could be included in on-call rotations.

Surgeons, too, are human beings with responsibilities towards families and partners. Can the system understand the human requirements and introduce flexible work models (ie, part-time or shared posts, especially in the peripheries rather than tertiary centers)

The College of Surgeons must take the lead in implementing pragmatic strategies toward enhancing job satisfaction, reducing burnout, and creating a sense of purpose for those most affected by this issue.

Without urgent intervention, the systemic collapse of surgical services will become inevitable, leaving patients, trainees, and the entire healthcare system in peril.

The time to act is now.

BRAIN DRAIN OF SURGICAL SPECIALISTS

AND IMMINENT FLOW REVERSAL OF SURGICAL CARE DELIVERY IN SRI LANKA

Dr Bingumal Jayasundara
Consultant Surgeon, Base Hospital, Balapitiya

Sri Lanka entered the new millennium carrying the burden of the ongoing terrorism in North and East that has been a growing threat to the safety of all citizens since the mid-1970s. It was also the time period when the rest of the country was slowly recovering from the negative repercussions of the 88/89 turmoil, which took over 60000 lives of youth. Subsequently, the Tsunami in 2004 devastated the country's economy, taking down over 40000 lives within a few minutes, with destruction of the entire coastal belt. Although three decades of terrorism in North and East, which distressed the lifestyle of Sri Lankans, was defeated in 2009, the country failed to gain any momentum to climb up from the low-middle income category position. The main reason for such failure was considered to be the 'established' corruption in the country. The Easter Sunday blast in 2019, followed by the Covid-19 pandemic in 2020-21, disrupted the daily routine, mindset, and social well-being, and created a sense of insecurity among the Sri Lankans.

All these events led to the economic bankruptcy in Sri Lanka in mid-2022, resulting in the dissolution of the government in power that had received two-thirds of the majority votes a couple of years back. Subsequent IMF reforms further strangulated the safe and secure lifestyle of the professionals of the upper-middle socioeconomic category.

Many professionals, including specialists and middle-grade doctors who had promising professional opportunities in Europe and Australia, fled away from the island, which was a sinking ship at that moment. Politicians and officials did their best to hide the gravity of this issue from the public. Twenty-five years into the millennium, we have almost reached the point of no return to recover the disruption of the state sector medical and surgical services of the country.

All these events led to the economic bankruptcy in Sri Lanka in mid-2022, resulting in the dissolution of the government in power that had received two-thirds of the majority votes a couple of years back.

The COVID-19 pandemic reversed human civilization back at least a decade. Aftermath of the Easter Sunday attack, economic bankruptcy, and recent socio-political instability has placed Sri Lanka at least two decades behind the rest of the world. It is no surprise that professionals consider leaving such a country not only for the individual benefit but for the stability of the future of their family and children.

The rulers of the country have not taken any reasonable steps to retain this highly skilled professional workforce. No wonder that medical professionals are becoming a category of slow extinction in Sri Lanka. With the effect of mass migration of medical professionals leading to a massive deficiency of the health care workforce, especially the specialists, could Sri Lankan

health care providers maintain the services at least as it was at the beginning of the millennium? Would Sri Lankan citizens accept the care and quality of health services as in the 1990s, twenty-five years into the twenty-first century? Would the patients be satisfied with such medical and surgical service?

That was the era when flexible endoscopies were a rarity on the island. That was when surgeons had no access to CT or MRI imaging in Sri Lanka. It is the bleak era when major bowel resections and oesophagectomies were performed without current day image staging, neoadjuvant therapy, and many times without the expertise of specialist anaesthetists. Would the surgeons be satisfied with such a level of patient care in 2025?

Review of Ministry of Health data on specialists' annual transfers 2025 shows that over 30% of general surgery and over 40% of anaesthesia specialist positions have been left vacant without an adequate number of applicants. At the moment, there are districts and sometimes provinces without the services of neuro-, vascular, and plastic surgery specialists in Sri Lanka. Mass migration of specialists has clearly disrupted patient care in the country, and surgery and anaesthesia have been specialties that bear the highest negative outcome. Surely, the ones remaining on the island would have been overburdened with the redundant workload.

The ministry has no strategy to retain young specialists returning from overseas training. Junior specialists posted to the forsaken ends of the country without adequate facilities gain no job satisfaction. For example, trainee surgeons who get exposed and trained in line with global clinical standards sometimes would only have the facilities to perform lump/bump excisions as a surgical junior. They would not have reasonable work conditions, accommodation, or transport facilities. There would be no incentive for them to remain here.

Unfortunately, neither the general public nor the political stakeholders has failed to understand the gravity of this issue. The public would realize this only when it affects the individual personally or when the health indices of the country eventually fall below basic standards, which would be too late to rectify. Political hierarchy and administration appear to turn a blind eye on this issue. Their ignorant slogan that 'the doctors who have been products of free education should serve the country' would never resolve this situation.

In the twenty-first century, where the world has turned into a global village, any professional, according to their capacity and regulations of the employer, should have the freedom and right to work anywhere in the world, provided the legal requirements have been covered at both ends. Sri Lankan medical specialists generally bear a monetary or service bond following their overseas training with the Ministry of Health. As long as they clear such obligations, the country has no right to force them to stay here unless during a dictatorship.

If the country requires to retain their professionals for the betterment of the citizens, such professionals need to be appreciated and treated with due respect. As the political hierarchy appears to be ignorant and higher medical administration acts with utmost lethargy on this matter, professional bodies may have to take leadership to halt the medical brain drain to save the quality of the country's health care service provision.

A MIGRATED SURGEON'S PERSPECTIVE:

WHY LEAVING SRI LANKA WAS THE RIGHT CHOICE

Anonymous
A General Surgeon now practising in Australia, who wishes to remain anonymous

At the outset, my decision to migrate was not made lightly. It was a collective family choice—one driven by the pursuit of a better work-life balance, financial stability, and enhanced opportunities for my children. While my heart remains connected to Sri Lanka, the systemic failures in our healthcare system left me with little choice but to seek a future elsewhere.

The Breaking Point: Challenges in Sri Lanka's Surgical System

Lack of Structured Post-MD Training

I was one of the batch of trainees when Sri Lanka first introduced special interest training. The PGIM introduced a special interest pathway for general surgery whilst having no structured post-MD training plans. There was no clear pathway. Overseas placements were haphazard, and returning specialists often found themselves stuck in peripheral hospitals with no opportunity to utilize their advanced skills. The constant change of principles and direction of the PGIM, putting the careers of trainees on the line, erodes the trust in the system.

As I understand, the PGIM is now in the process of abolishing the special interest training that was introduced earlier. Lack of a clear vision, poor collective coordination with the Ministry of Health on policies, and constant change of direction only lead to the creation of groups of trainees with no clear identity, who are left alone to fend for themselves at the whims of the Ministry of Health.

Ministry of Health: A Bureaucratic Nightmare

The Ministry of Health's TCS branch was a source of immense frustration—slow, inefficient, and outright disrespectful to returning specialists. I trained in laparoscopic colorectal surgery in the UK, only to return to a system where basic equipment was lacking, and seniority, not expertise—dictated transfers. Delays in appointments, lack of support for overseas-trained doctors, and zero consideration for family needs (like my wife's overseas training) made it clear: the system was designed to discourage, not retain, skilled professionals.

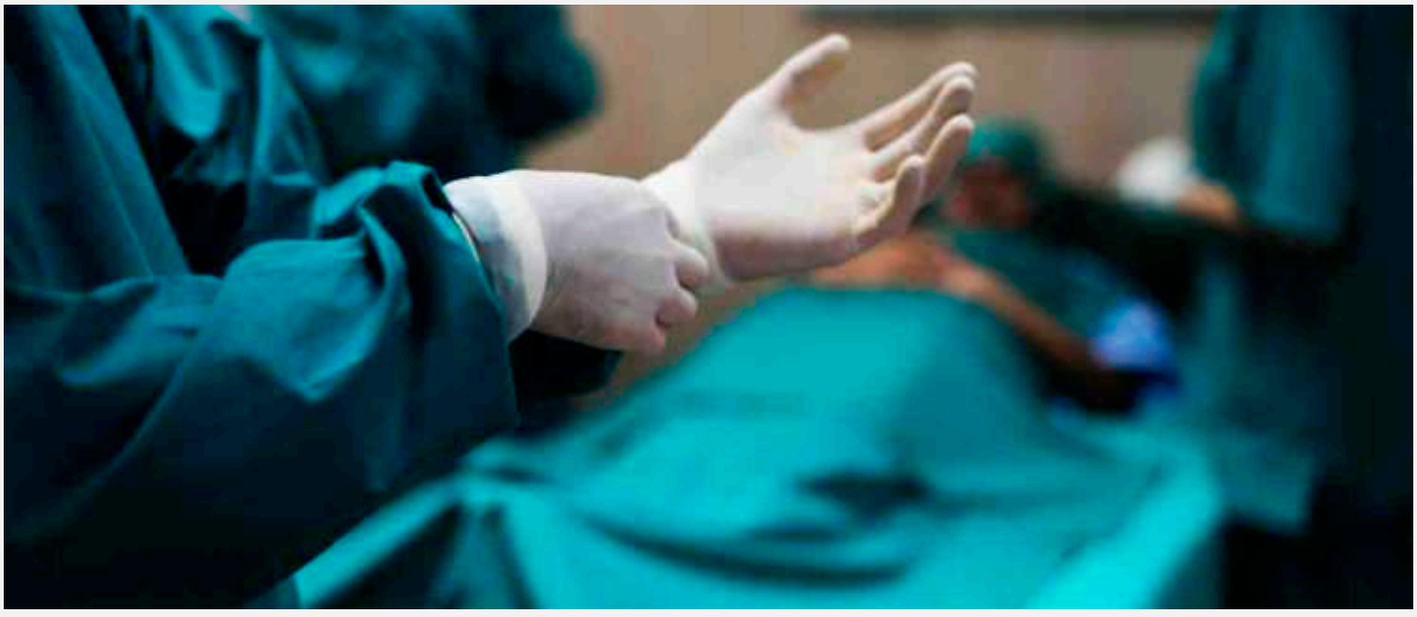
The Reality of Peripheral Postings

Working in rural hospitals was rewarding yet deeply frustrating. Lack of surgical equipment, drugs, non-availability of anesthetists, and lack of ICU facilities completely tied our hands at times, causing considerable frustration as young consultants. Whilst there were problems that we could personally mediate and rectify, there were many issues that did not have a solution for years in many hospitals. I returned having trained in laparoscopic colorectal surgery, and I often got fed up not having the opportunity to practice what I was trained to do. Often, the response from the senior surgeons was to be patient until we get posted to a bigger centre years later, from annual transfer lists. Considering the seniority-based transfer system rather than an expertise-based appointment system, there was little hope of an opportunity to get to work in a decent institution.

To add to the woes of the long hours of travel, most peripheral units have poor residential conditions, and all this with the frustration of having to be away from our families most of the time. My wife was in Colombo looking after our children whilst studying for her postgraduate exams. In Sri Lanka, it is not practical to tag along with your family to all peripheral locations due to the inequity of facilities and schooling.

My wife, also a doctor, battled on with her postgraduate training while managing our children, and that too alone in Colombo, managed to complete her training. When I requested leave to accompany her during her overseas training, the system refused to accommodate—this was the final straw.

> Considering the seniority-based transfer system rather than an expertise-based appointment system, there was little hope of an opportunity to get to work in a decent institution.



Personal experiences while working overseas (UK and Australia)

Whilst work in the UK and Australia can be quite intense during working hours, the superior wages and protected time off ensure a much better work-life balance. Good income automatically translates to improved quality of life. I have personally found that I was more available to my family at times of need whilst working overseas compared to when I was working in peripheral Sri Lanka.

Foreign countries promote flexibility with options to work part-time in case of challenging periods. This ability for oneself or your partner to work part-time is a great option available in most developed countries. There is then the opportunity for both partners to advance in their career at their own pace whilst not compromising childcare/ family responsibilities. This is not an option in Sri Lanka unfortunately.

The opportunity to travel the world, explore beautiful locations, and enjoy as a family certainly became a reality whilst working overseas. It is needless to elaborate that educational and other opportunities are much broader for children

> The opportunity to travel the world, explore beautiful locations, and enjoy as a family certainly became a reality whilst working overseas.

Final Reflection: A Bittersweet Choice

I deeply admire and respect all my colleagues who continue serving in Sri Lanka despite these challenges. Finally, something more and more I have realized is that there is much more to life! While it is important to serve humanity, there are numerous other things one could do with your loved ones with the limited time we have all had.

Indeed, we all remain forever Sri Lankan by heart. I believe that Sri Lanka loses its progeny not because they lack patriotism, but because the system fails them. Until that changes, the exodus will continue.

> While it is important to serve humanity, there are numerous other things one could do with your loved ones with the limited time we have all had.

THE PULSE

COLLEGE ACTIVITIES

18th Basic Laparoscopic Skills Workshop

Cadaveric Operative Surgery Training (COST)

Common Selection Examination for Surgical Specialties

Emergency Sonography for Trauma Care (ESTC)

ATLS®

Surgical Education and Training Sessions (SETS)

National Trauma Management Course and Initial Trauma Care for Nurses

Interactive Small group discussion on Communication skills and non-technical skills followed by a mock OSCE aimed at MD and MRCS

Online Teaching for Surgical Trainees (OTST)

18th Basic Laparoscopic Skills Workshop

The 18th Basic Laparoscopic Skills Workshop for surgical trainees was conducted on the 23-24th January at the Skills Lab of the College of Surgeons. The workshop is a joint venture organized by the SLAMADS and the College of Surgeons of Sri Lanka.

The course is hugely popular among surgical trainees, especially those who have just started their surgical training, and also among advanced trainees who want to develop and improve their laparoscopic skills.

The expert faculty was led by course director Prof Bawantha Gamage and course coordinators Dr. S H R Sanjeewa and Dr. M A C Lakmal.

Cadaveric Operative Surgery Training (COST)

COST is a hands-on workshop featuring cadaver-based training in surgical procedures followed by a mock operative surgical viva. It's a joint venture between the Department of Anatomy, Genetics, and Biomedical Informative and the Department of Surgery of the University of Colombo in collaboration with the College of Surgeons of Sri Lanka.

This year COST was conducted on the 17th of January at the Department of Anatomy, Faculty of Medicine (UCFM), Colombo.

Trainees carried out cadaver-based dissections of common operative procedures both elevetive and emegency. Course directors Prof Ajith Malalasekara and Prof Dakshitha Wickramasinge together with a multi-speciality resource person panel conducted an extremely successful course.

Common Selection Examination for Surgical Specialties

The preparatory workshop for prospective surgical trainees who are hoping to sit for the common selection examination (previously part 1) was conducted on the 4th of January 2025 at the Auditorium of College of Surgeons of Sri Lanka.

The course provided an introduction to the syllabus as well as the spectrum and depth of the examination, followed by a mock OSCE. It was extremely well attended with over 170 participants. Coordinator Prof Ajith Malalasekara together with a panel of experts discussed surgical anatomy, physiology, pathology, basics of surgical procedures, data interpretation, medical duties as well as communication & ethics; all the necessary knowledge, skills, and attitudes required to be an excellent surgical trainee.

Emergency Sonography for Trauma Care (ESTC)

The Course on Emergency Sonography for Trauma Care organized by the College of Surgeons of Sri Lanka in collaboration with the Accident and Orthopedic Trauma Unit of the Nationa Hospital of Sri Lanka conducted two workshops in February and April at the NHSL, Accident service auditorium. Both courses were over-subscribed for the maximum 25 participants per course.

The course aimed to provide a valuable learning experience as well as hands-on experience on FAST, vascular access, vessel assessment, use of USS for fluid resuscitation, etc.

Course coordinators, Dr. Mihira Bandara and Dr. Ashan Jayawickrama together with their faculty conducted two successful workshops during the first calendar quarter.

ATLS®

The College of Surgeons of Sri Lanka is the sole provider of the ATLS® program in Sri Lanka. ATLS® provides a systematic, safe, and reliable method of training in the immediate management of severely injured patients.

The Intensive and interactive February ATLS course was conducted on 14,15,16th of February at the College of Surgeons where 16 participants (maximum accommodated) received comprehensive training in a range of skills essential for the immediate management of the trauma patient.

The February course was conducted by an expert faculty of surgeons and anesthetists and was led by course coordinator Dr. Mihira Bandara.

Surgical Education and Training Sessions (SETS)

The College of Surgeons conducted three Surgical Education and Training Sessions, also more commonly known as SETS, during the first quarter. The SETS is a CPD-accredited training program conducted physically at the College of Surgeons Auditorium and is also transmitted live to Kandy, Peradeniya, Jaffna, Anuradhapura, Galle, and Batticaloa. SETS coordinator Dr. Ranga Wickramarachchi conducts the SETS program every month and is well attended with 30-50 surgical registrars joining onsite.

The February SETS program was case case-based discussion on Pancreatitis on February 8th, while March saw two SETS programs. One on Surgical conditions of the Oesophagus (March 1st) and one on Surgical conditions of the Stomach (March 29th)

National Trauma Management Course and Initial Trauma Care for Nurses

The 72nd NTMC and 33rd ITCN were conducted on 7-8th March and the 73rd NTMC and 34th ITCN were conducted on 8-9th April at the College of Surgeons of Sri Lanka with the participation of over 55 medical officers for NTMC and over 60 nurses for ITCN per course.

The National Trauma Management Course has been designed based on the guidance of the IATSIC (International Association of Trauma Surgery and Intensive Care). In partnership with the College of Surgeons of Sri Lanka NTMC and ITCN have been guiding healthcare professionals of Sri Lanka to empower them in the initial management of trauma.

Course director Dr. Kamal Jayasuriya and his mentor Dr. Ranjith Ellawala, Global chair, NTMC together with the panel of resource persons continue to conduct successful courses.

Interactive Small group discussion on Communication skills and non-technical skills followed by a mock OSCE aimed at MD and MRCS

The Non-operative technical skills course organized by the College of Surgeons was conducted on the 1st of March at the College of Surgeons Auditorium. 17 Participants including senior registrars, registrars, and MRCS candidates took part in the interactive course and provided excellent feedback.

Course Coordinator Dr. Minoli Joseph, together with the leadership of Dr. Jayaindra Fernando conducted a very successful course.

Online Teaching for Surgical Trainees (OTST)

OTST, The College of Surgeons online teaching program was initially established during the COVID era to provide continued surgical teaching when physical meetings weren't possible. Post-COVID it was realized that OTST was able to reach out to a wider surgical community. SHOs, MOs as well as surgical trainees, especially those who are in peripheral hospitals and are unable to physically join in due to work demand and travel distances can join in for the online program.

Coordinator, Dr. Chathuranga Keppetiyagama aims to further diversify the OTST program by introducing guest lectures on topics that go beyond the conventional core surgical areas.

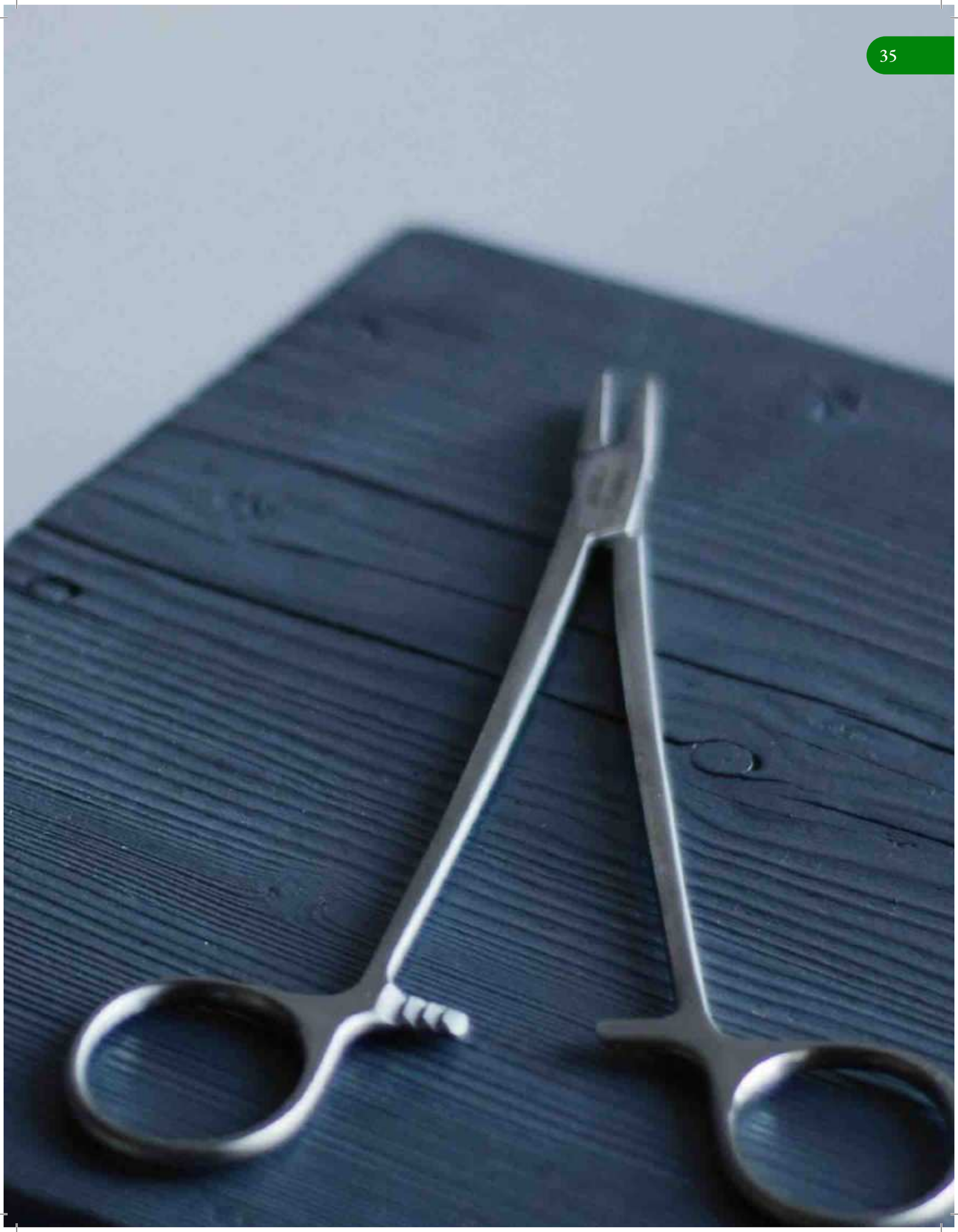
April saw a hugely successful OTST program on Sepsis management – Source control as a critical intervention delivered by Dr. Mahen Kothalawala, Consultant Microbiologist, NHSL.

FEATURES & NEWS

Subspeciality Activities

The “Golden Hour” - Trauma in Sri Lanka
Kamal Jayasuriya

From the Provinces - Provincial chapters of CSSL speak out



SUBSPECIALITIES ACTIVITIES

Sri Lankan Society for Vascular Surgery - Trimester Update

The Sri Lankan Society for Vascular Surgery (SLSVS) continues to advance vascular care through education, collaboration, and innovation under the leadership of Prof. Rezni Cassim and his council. Over the past trimester, the society has made significant progress in academic training, regional partnerships, and preparations for its flagship annual event.

Academic & Training Initiatives

The SLSVS Journal Club remains a cornerstone for critical appraisal, with senior registrars leading monthly discussions on recent publications. Highlights included analyses of upper and lower limb arterial trauma outcomes from the US National Trauma Bank, Systematic review and Meta-analysis on long-term mortality data following elective infrarenal AAA repair, and major adverse limb events in peripheral arterial disease patients from a Swedish national study.

Monthly Morbidity & Mortality (M&M) meetings provided valuable learning opportunities through case-based discussions on graft infections, limb ischemia, wound complications, and aortic issues, with a strong focus on systemic improvements for patient safety. The Expert review by Consultant Series featured well-attended talks by emerging experts, including Dr. Aruna Weerasuriya on aortic dissection, Dr. Donald Rubakan on, vascular access and Dr. Manujaya Godakandage on mesenteric ischemia.

SLSVS_25: Premier Vascular Event of 2025

Mark your calendars for SLSVS_25, the society's Annual Academic Sessions scheduled for 23-24 May 2025 at the Taj Samudra, Colombo. This premier event will bring together more than 25 international faculty members from Europe, Asia, and Australia alongside our own local experts. The program will cover cutting-edge topics including vascular trauma, acute limb ischemia, chronic limb-threatening ischemia, aneurysmal disease, diabetic limb salvage, and venous disorders. A special SAARC session will foster regional collaboration. Early registration is encouraged to secure participation.

Northern Collaboration: Wound Care Workshop

In a landmark collaboration, SLSVS supported the Jaffna Medical Association to conduct a comprehensive CME program on wound care. The event featured lectures on best practices in chronic wound management, vascular ulcers, and infection control, complemented by hands-on training in debridement techniques, compression therapy, and dressing selection. Over 80 healthcare professionals participated, with plans underway to expand this successful initiative to other regions.

Leadership Transition

As Prof. Cassim's council prepares to conclude its successful two-year tenure following SLSVS_25, the society acknowledges their exceptional contributions. Their legacy includes strengthened training pathways, enhanced international collaborations, and groundbreaking outreach programs that have elevated vascular surgery nationally. A formal handover to the newly elected council will occur at the Annual General Meeting following SLSVS_25.

Sri Lanka Association of Minimal Access and Digital Surgeons (SLAMADS) Activities in the Q1 of 2025

SLAMADS has been at the forefront of teaching, training, and advancing minimally invasive surgical techniques since its inception 5 years ago. The first quarter of 2025 has been particularly vibrant for the organization. With a commitment to education, collaboration, and innovation, SLAMADS has successfully conducted a series of workshops and webinars aimed at enhancing the skills and knowledge of laparoscopic surgeons and trainees across the country.

1. Workshops

SLAMADS continued its tradition of conducting its regular workshops as well as conducting peripheral workshops aimed at uplifting minimal access surgery in Sri Lanka.

18th Basic Laparoscopic Skills Workshop for Surgical Trainees

In January 2025, the SLAMADS commenced its quarterly activities with its customary Basic Laparoscopic Skills Workshop for Surgical Trainees on the 23rd and 24th of January. This mandatory training workshop is designed to impart essential skills to surgical trainees. The workshop comprises a structured curriculum that emphasizes basic knowledge and skills crucial for proficiency in laparoscopic procedures. Held at the College of Surgeons of Sri Lanka, the event attracted surgical registrars with great enthusiasm.

Laparoscopic Colorectal Surgery; Learn from the experts

The workshop on 'Laparoscopic Colorectal Surgery – Learn from the experts' was held on January 30, 2025, at Teaching Hospital, Batticaloa. This workshop was organized by the College of Surgeons of Sri Lanka, SLAMADS, and the Batticaloa Medical Association. Twenty participants, including consultants and surgical trainees, attended the session. These workshops ensure equitable access to advanced surgical education nationwide. SLAMADS will continue organizing similar workshops nationwide.

Laparoscopic Approach to Inguinal Hernia Repair

Another notable workshop on Laparoscopic Inguinal Hernia Repair was held on March 15, 2025, at the National Hospital in Kandy. The event showcased live demonstrations of laparoscopic hernia repair techniques, including TEPP, TAPP, IPOM, and eTEP. The workshop was a resounding success, attracting active participation from surgeons and trainees throughout the country.

2. Webinars

Embracing digital technology SLAMADS continued its live webinar series in Q1 of 2025. These webinars attracted good participation and the contents were well received by participants.

Following live webinars were hosted.

Minimal access fistula surgery

Dr. R. Rajaganeshan, Consultant Colorectal Surgeon. Mersey & West Lancashire Teaching Hospitals NHS Trust

Dr. Rajaganeshan presented a comprehensive overview of the diverse surgical options available through a minimally invasive approach for fistula surgery.

Laparoscopic Approach to Inguinal Hernia Repair

Dr. Chandika Liyanage, Consultant General, Upper GI & HPB Surgeon, University of Sydney, Dubbo Campus

Dr. Liyanage elucidated the fundamental principles and theoretical underpinnings of laparoscopic inguinal hernia repair, providing a comprehensive demonstration through a video presentation. approach for fistula surgery.

3. Annual General Meeting 2025

SLAMADS held its Annual General Meeting on February 1, 2025, at the College of Surgeons in Colombo. Key resolutions were deliberated and duly approved. The election of new council members was held, resulting in the election of Dr. V. Sutharshan as the new President and Dr. R. Manathunga as the President-Elect. Additionally, the positions of Joint Secretaries, Treasurer, and council members were also filled. The outgoing President, Prof. Bawantha Gamage, addressed the gathering, expressing gratitude for the support received. Furthermore, a snapshot of audit data on laparoscopic facilities in Sri Lanka was presented.

4. Contributions from SLAMADS

SLAMADS membership enjoys global acceptance. It has established robust partnerships with similar organizations worldwide. The quarterly SLAMADS newsletter is disseminated via the ALSGBI website. It is also shared with the membership of the Associations of Laparoscopic Surgeons of India (AMASI) and Korea (KSERS).

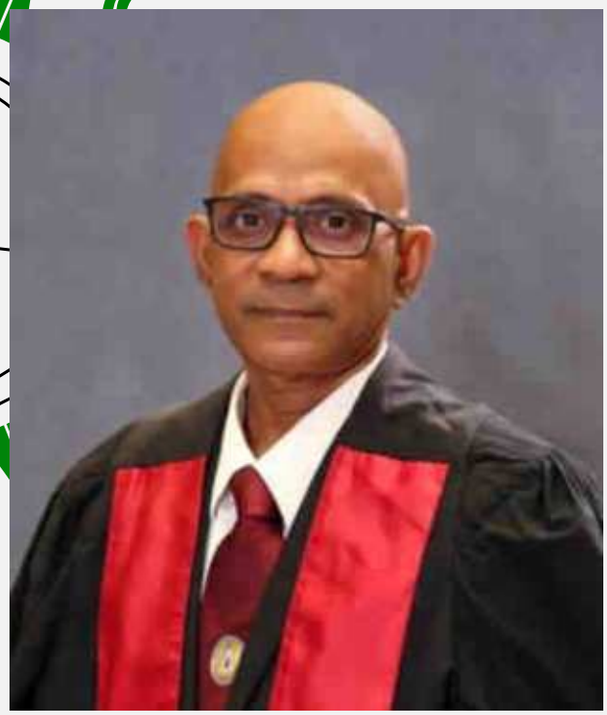
Furthermore, the founder president of SLAMADS, Prof. Bawantha Gamage, has contributed as faculty to several international webinars and courses. Notably, he participated in the MMAS (Colorectal) course held in Kochi, India. Additionally, he has contributed to a few webinars conducted by GEM Televersity and the Philippine Center for Advanced Surgery.

5. Website and Newsletter

SLAMADS e-Newsletter (Volume 6, Issue 1) has recently been published and is available for online viewing on the SLAMADS website (www.slamads.lk). SLAMADS website has frequently been updated and features upcoming events and a video library.

THE "GOLDEN HOUR"

TRAUMA IN SRI LANKA



Dr Kamal Jayasuriya
MBBS, MS, FCSSL, FISS, FAACT, FMAS | Consultant Surgeon | Director NTMC | National Delegate ISS Country representative & Fellow of ACT | Instructor ATLS Singapore | Instructor DMMT, ITCN

DO WE NEED TO REPLACE THE TRAUMA SYSTEM IN SRI LANKA? TO OPEN THE MINDS OF POLICYMAKERS.

Implementing a standardized trauma system significantly improves patient outcomes. Patients with life-threatening but salvageable injuries are six times more likely to die in low-income settings (36% mortality) compared to high-income settings (6% mortality). Mortality rates rise sharply across income levels—from 35% in high-income settings to 55% in middle-income settings and 63% in low-income settings. Over the past two decades, trauma center closures have increased; between 1999 and 2005, 390 of the 1,125 trauma centers in the United States (30%)2.

When establishing a trauma system, potential challenges must be identified. The socio-cultural and political context of the healthcare infrastructure must be thoroughly understood, especially in resource-poor and fragile settings.

> Sri Lanka has 517 primary care hospitals (classified as Level 4 trauma centers), each staffed with doctors and nurses and equipped with an ambulance within a 4 km radius.

Trauma Burden in Sri Lanka

Sri Lanka faces unique injury patterns, including animal attacks, trap gun injuries, falls from trees, and agriculture-related cuts and fractures. Many incidents occur in remote areas with no network coverage or emergency medical services (EMS) access, often deep in jungles. Victims are typically transported by locals using improvised methods to the nearest medical facility.

Sri Lanka has 517 primary care hospitals (classified as Level 4 trauma centers), each staffed with doctors and nurses and equipped with an ambulance within a 4 km radius. These facilities should, in theory, manage airway, breathing, circulation, and disability (ABCD) in trauma cases.

Gaps in the available system

While all primary care hospitals have staff and ambulances, only two are equipped for intubation, and none can perform intercostal tube insertions. As a result, major trauma victims receive minimal resuscitation before transfer to higher-level facilities. Key deficiencies include:

Key deficiencies include:

Lack of equipment
(airway management tools, adjustable cervical collars, head blocks, spinal board straps).

Insufficient training
(intubation, chest tube insertion, fluid resuscitation).

Poor administrative awareness
of trauma resuscitation needs and transfer protocols.

Even in tertiary centers with Emergency Trauma Units (ETUs), significant delays persist:

- ETU doctors often wait for anesthetics teams to intubate or radiology teams for eFAST (extended Focused Assessment with Sonography in Trauma).
- Delays in obtaining uncross-matched blood and surgical teams for intercostal tube insertion hinder timely interventions.
- Inter-provincial transfers are restricted, delaying specialty care. For example, suspected intracranial hemorrhage (ICH) patients with stable Glasgow Coma Scale (GCS) scores are transferred for CT scans but may need to return if neurosurgical care is required.

> ...Improving existing structures and manpower is the most cost-effective and practical approach to enhancing trauma outcomes until a formal system is established.

Systemic Challenges

- WhatsApp-based CT image reviews by neurosurgical teams sometimes lead to delayed transfers, compromising cerebral perfusion.
- Peripheral hospital staff are often held until neurosurgical procedures are completed, straining local resources.
- Despite the National Trauma Management Course (NTMC) teaching resuscitation and transfer principles, many patients remain ventilated in general wards due to a nationwide ICU bed shortage.
- Trauma-specific contrast-enhanced CT (CECT) is unavailable in most tertiary hospitals. Delays stem from serum creatinine testing requirements, nephrology consultations, and radiologist availability.
- Non-contrast CT scans remain suboptimal for trauma assessment.
- Polytrauma patients are sometimes managed by subspecialty teams (e.g., orthopedics, OMF) without holistic assessment, worsening outcomes.

Urgent Need for Reform

Sri Lanka has waited nearly two decades for a trauma registry and system—progress remains stagnant. Waiting another twenty years is unacceptable. Improving existing structures and manpower is the most cost-effective and practical approach to enhancing trauma outcomes until a formal system is established.

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FROM THE PROVINCES

Central Chapter

The Central chapter of the College of Surgeons of Sri Lanka under the leadership of Dr Achala Samarasinghe initiated the academy year with a successful workshop on Minimal Access Hernia Surgery aimed at both consultants and trainees. The workshop was held on 15th March 2025. It was followed by a theatre training workshop for the operating theatre assisting staff of the central province, providing leading and training opportunities. The chapter hopes to conduct the basic surgical skills courses for senior house officers in surgery shortly.

Executive council

- President - Dr. Achala Samarasinghe
- Vice president - Dr. A.W.M. Sameem
- Secretory - Dr. S. Sutharshan
- Treasurer - Dr. Prabath Pathirathna
- Chapter representative - Dr. Buddhika Thilakarathna

Mastering Laparoscopic Hernia Repair:

"Minimal Tools, Maximal Mastery!"—the theme of the live surgical workshop on Laparoscopic Hernia Repair held on 15th March 2025 at the National Hospital, Kandy, truly lived up to its spirit. Organized under the aegis of the Central Chapter of the College of Surgeons of Sri Lanka, in collaboration with SLAMADS, this workshop was conceptualized and organized by Dr Achala Samarasinghe.

The workshop featured live surgical demonstrations, led by Dr.V.Sutharshan, that enabled participants to observe step-by-step procedural nuances—right from port placement and space creation to mesh fixation and peritoneal closure.

The sessions were attended by a diverse group of consultant surgeons and surgical trainees from across the country.

Empowering Theatre Staff Through Hands-On Training: A Successful Workshop at Hanthana Simulation Centre

A highly successful Theatre Training Workshop was held on 26th March 2025 at the Simulation Centre, Hanthana, offering a day of immersive and practical learning for surgical unit attendants from National Hospital Kandy.

This essential training initiative was organized by the Postgraduate Medical Centre – Kandy, in collaboration with the College of Surgeons – Central Chapter. The workshop was specifically designed to upskill theatre attendants in crucial aspects of surgical support.

The training included a balanced combination of interactive lectures and hands-on skill stations, covering key areas such as safe transfer of patients, proper patient positioning for surgery, assisting in anesthesia procedures, safe and effective use of diathermy, patient warming techniques, and basic life support (BLS).
The event was spearheaded by Dr. Achala Samarasinghe, who played a pivotal role as the chief organizer. The organizing and resource team included Dr. Thilak Wijeratne, Dr. LRPKB Udapamunuwa, Dr. Senani Samarasinghe, Dr. Sidarshi Kiriwaththuduwa, and Dr. Upali Chandrasiri, whose contributions were instrumental to the success of the workshop.

Northern Chapter

The Northern Chapter of the College of Surgeons of Sri Lanka (CSSL) commenced 2025 January under the presidency of Dr. S. Gobishangar, with a strong focus on enhancing surgical knowledge and interdisciplinary collaboration through a series of impactful events and workshops.

Executive council

- President - Dr. S. Gobishangar
- Secretory - Dr. S. Vinojan
- Treasurer - Dr. S. Majooran
- Editor - Dr. V. Thanushan

Workshop on Amputation - "Do it Right the First Time - All About Amputation"

January 6, CTRB Building, Teaching Hospital Jaffna.

This workshop was initiated by Dr. T. Gobishangar and organized by Dr. S. Vinojan to improve amputation techniques and postoperative care. It brought together 34 participants and a multidisciplinary panel of clinicians from across the Northern Province.

The Jaffna Jaipur Centre, a pioneer in amputee rehabilitation since 1987, was a major contributor, with staff and two amputees sharing valuable insights. The success of the event has prompted plans to make it a recurring program to improve surgical outcomes in amputee care.

Wound Care Workshop

The workshop coordinated by Dr. S. Vinojan, was led by expert vascular surgeons from across Sri Lanka, ensuring a high standard of training and knowledge sharing and successfully executing the goal. This comprehensive workshop catered to 40 doctors and 80 nurses, focusing on the management of chronic and complex wounds.

Topics Covered included, callosity shaving, demonstration and usage of various wound dressings, application of compression bandages, testing for sensation, vascular examination for foot ulcers, drainage techniques for diabetic foot abscesses, hands-on wound dressing techniques, etc

Upcoming Events for April from the Northern Chapter are,

- Dinner Talk - Title: "Bone Tumors Throughout the Time – From Ancient Fossils to Future Therapies" for April 23rd
- HPB (Hepato-Pancreatic-Biliary) Workshop on April 24

The Northern Chapter of CSSL continues to demonstrate its commitment to surgical excellence and community health through education, collaboration, and innovation.

Eastern Chapter

Established in 2017 under the patronage of Prof. M.D. Lamawansha and Prof. Mohan De Silva, with Dr. P. Jeepara as Founding President. The chapter remains actively involved in regional and national surgical initiatives.

Executive council

- President - Dr. P. Jeepara
- Vice president - Dr. A.W.M. Sameem
- Secretory - Dr. S. Sutharshan
- Treasurer - Dr. Prabath Pathirathna
- Chapter representative - Dr. Buddhika Thilakarathna

Advancing Laparoscopic Skills in the East: Successful Colorectal Surgery Workshop in Batticaloa

The Eastern Chapter of the College of Surgeons of Sri Lanka, in collaboration with the Sri Lanka Association of Minimal Access and Digital Surgeons (SLAMADS) and the Batticaloa Medical Association, successfully conducted a Workshop on Laparoscopic Colorectal Surgery on 30th January 2025 at the Teaching Hospital, Batticaloa.

Workshop Highlights included expert-led live surgeries. laparoscopic anterior resection, laparoscopic right hemicolectomy etc. Expert resource persons were Dr. Rasitha Manathunga (Consultant Oncological Surgeon) and Dr. Rasika Bulathsinghala (Consultant Gastroenterological Surgeon).

The workshop included hands-on sessions and case discussions enriching participants' understanding of advanced minimally invasive techniques. This session was attended by 20 participants, including consultants and surgical trainees. These enthusiastic and energetic peripheral consultants came from all parts of the eastern province covering all three districts.

The workshop addressed a critical need by bringing high-quality surgical education to regional practitioners, reducing dependency on Colombo-based training. Participants highlighted the practical value, expert mentorship, and seamless coordination—including well-managed logistics and hospitality.

Special appreciation to Dr. Buddhika Thilakarathna (Course Coordinator) for meticulous planning as well as the Faculty, organizers, and hospital staff for their dedication.

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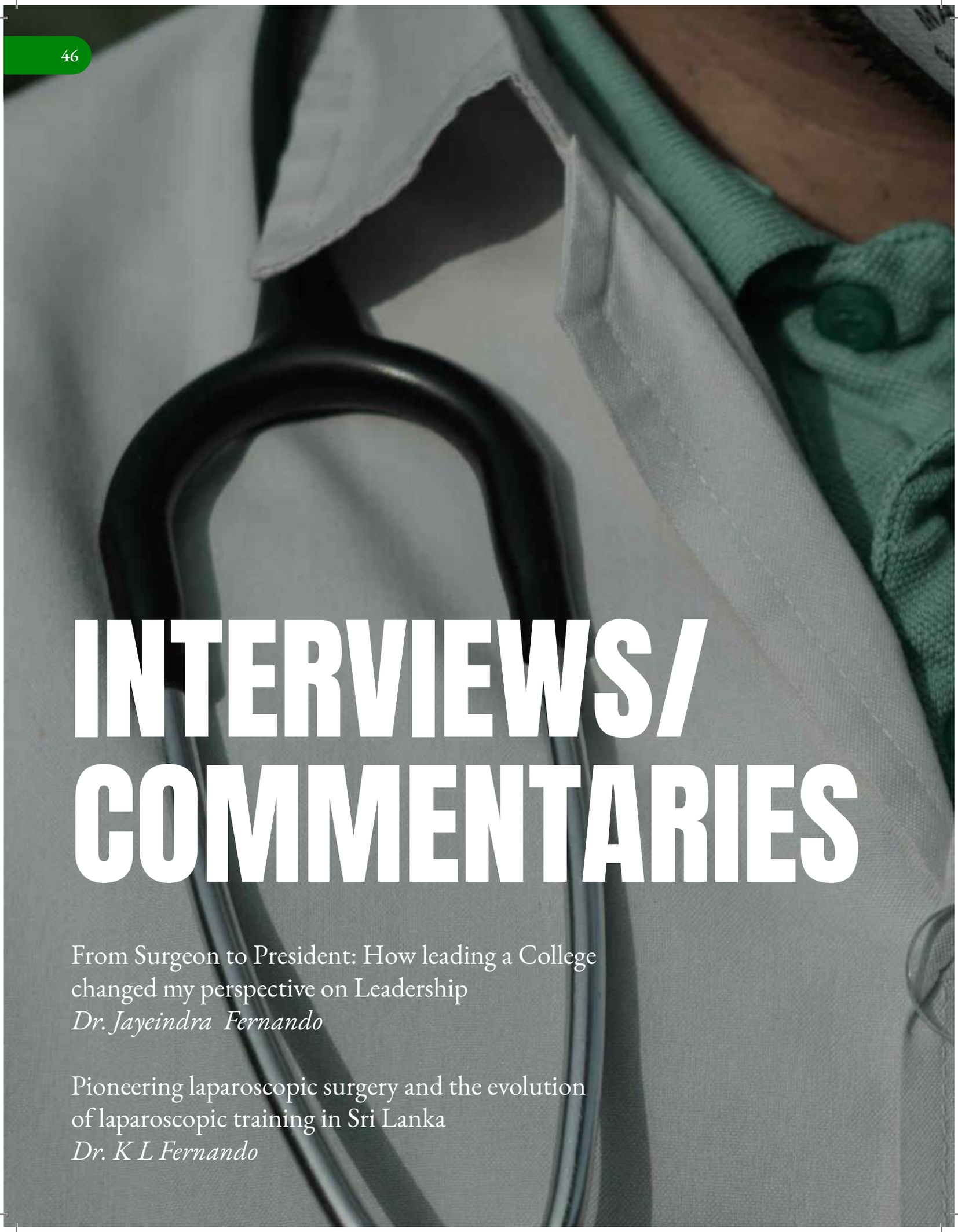


INTERVIEWS/ COMMENTARIES

From Surgeon to President: How leading a College changed my perspective on Leadership
Dr. Jayeindra Fernando

Pioneering laparoscopic surgery and the evolution of laparoscopic training in Sri Lanka
Dr. K L Fernando


2000
KIMIYA

FROM SURGEON TO PRESIDENT:

HOW LEADING A COLLEGE CHANGED MY PERSPECTIVE ON LEADERSHIP

Dr Jayaindra Fernando
MBBS, MS, FCSSL (Hony), FASIndia (Hony), FRCESd (Ad hom)
Consultant General Surgeon,
Past President – College of Surgeons of Sri Lanka 2020 | RCSEd International Surgical Advisor for Sri Lanka

As I write this note, it is almost 5 years since I assumed the role of serving this noble college as its president. Looking back many recurring thoughts regarding leadership occur, few of which I considered sharing with you. My comments through this article are equally valid for council as well as provincial chapter committees and college subcommittees.

One matter for consideration is the difference between corporate leadership and leadership of a professional college such as ours. Fundamentally a corporate entity is a business enterprise, the success of which is judged daily, quarterly and annually by at least two indicators. Firstly, the profit it makes, commonly called the bottom line in reference to the bottom most figure in a set of accounts. Secondly the return on equity (ROE) being the profit per owners' investment. These are tangible, measurable and described in numbers.

One matter for consideration is the difference between corporate leadership and leadership of a professional college such as ours.

As for CSSL, it has a dual role. Its secondary role is to run the office, building and the establishment very much as a corporate entity described above. These are described under Ancillary powers in the incorporation memorandum which is the de facto constitution of the College.

However, the primary role of the CSSL is to fulfil primary objects set out in the incorporation memorandum, namely, to advance the practice of surgery. The success of these primary objects is mainly intangible and long term. What the college does for its members, the profession, the community and the country cannot be counted nor described in numbers in the short and medium term. Over the long term, the contribution made by the CSSL is intermixed and diluted with contributions by other stake holders.

The CSSL leadership bodies are large and broad-based entities composed of volunteers who are otherwise extremely

At council meetings a smart and rational argument presented assertively was often accepted speedily. The opposite was also true. A dumb idea would be rejected with equal speed, enthusiasm and persuasion.

busy. They are not renumerated nor formally evaluated post service. This compares opposite to the usual small corporate board or a larger structured senior management team of a mercantile unit, who are paid for the job and evaluated on the service product. The leadership requirements in these two groups are vastly different.

Each member of the CSSL council is highly educated, well-travelled, with proven ability and efficiency, high income earning and strongly opiniated. Each member fit to be a president and many in my council probably were more suitable than me for that role!! On paper a difficult crowd to control and lead. The reality was and would be just the opposite, just as my predecessors had primed me to believe.

At council meetings a smart and rational argument presented assertively was often accepted speedily. The opposite was also true. A dumb idea would be rejected with equal speed, enthusiasm and persuasion. The president's role was to accept both states with equal cheerfulness. Most ideas presented were never so good nor dumb but a state in between. Thus, the need for a council meeting! My role as president was to nudge the assembly towards a modified and improved consensus, keeping in mind the Churchill doctrine that pragmatism is better than being good, at least at times.

The heterogeneity in many ways within the council and other leadership structures makes them interesting. The age and experience range in my council was a bell curve, which was ideal. It facilitated diffusion of knowledge and wisdom down the concentration gradient and as well as wise folk encourage, in the opposite direction too as a form of osmosis. A good age mix of the council lead to "controlled incremental change" without a need for a "self-damaging system change". It is worth remembering that non-execution of the former would inevitably lead to the latter. Evolution is safer than revolution. CSSL members voting in council elections should be cognizant of this need. If the reader is thinking that I am implying that my year 2020 was an extraordinarily good council, it is a wrong assumption. I am only exposing a non-randomized biased sample of council operations painted over by COVID pandemic. While my 2020 council was the best I could have ever wished for, it is also true for every council year that I have been a part of. I was privileged to observe many variations of this excellence while serving 18 council terms between 2001 and 2024.

A stimulus that makes each president to sacrifice time, energy and income capacity for the sake of the college is the unrestricted and perpetual altruism and volunteerism displayed by the council members as well as other members and office staff. I was the happy recipient of all this. While it is stated that a leader's role is to inspire and lead the team, it was a pleasant discovery that the reverse also occurs. Inspiration and smart ideas flow bottom to top provided the leader keeps the heart and mind open for such a reception.

While the subject of transformational leadership is often dealt with in leadership programs, less is said about leaders who undergo transformation themselves. This was so true for me as leadership opportunity was a learning experience with the curve steep at times. This was not totally unexpected as my predecessors had predicted it and likened the process to a university course. The positive human experience of leading the CSSL was most pleasant and had a lasting impact on me.

The cycle of life is bound to continue at CSSL as it does in the world in general. After the pleasure of leading the college, the joy continues as I observe those younger (and older) than me take on increasingly heavy responsibility and deliver the goods with confidence and finesse. Unsurprisingly each cycle is executed better than the previous, leading to the inevitable and unrelenting advancement of the college.

While it is stated that a leader's role is to inspire and lead the team, it was a pleasant discovery that the reverse also occurs. Inspiration and smart ideas flow bottom to top provided the leader keeps the heart and mind open for such a reception.

PIONEERING LAPAROSCOPIC SURGERY

AND THE EVOLUTION OF LAPAROSCOPIC TRAINING IN SRI LANKA

Dr K. L Fernando
(Hony), Dip in Archeology | Past President of College of Surgeons (2011)
Performed the first Laparoscopic cholecystectomy in Sri Lanka in June 1992.

The world's first Laparoscopic Cholecystectomy was performed in March 1987 by a French surgeon with gynecological experience Phillipe Mouret of Lyon. This revolutionary technique opened a new era of minimally invasive surgery and spread rapidly in the Western world. In 1990, I had the opportunity to visit the Hospital International of the University of Paris with my Consultant at Maidstone Mrs Marie South and be trained in this technique under Professor Francois Dubois. I gained more experience in this procedure from 1990 to 1992 while working in the UK.

Laparoscopic surgery, a revolutionary advancement in minimally invasive procedures, was first introduced to Sri Lanka in June 1992 when I performed the country's first Laparoscopic Cholecystectomy using my instruments, which I procured while in the UK out of my funds. This milestone marked the beginning of a transformative era in surgical practice, one that offered patients shorter recovery times, reduced postoperative pain, and minimal scarring.

Determined to popularize this technique across the country and make it widely accessible to patients I initially focused on introducing Laparoscopic procedures to the private sector, persuading institutions to invest in this groundbreaking technology and facilitating its widespread adoption. During this period, I recognized the urgent need for structured laparoscopic training for young trainee surgeons in Sri Lanka. A major hurdle in training was the prohibitive cost of commercially available laparoscopic trainers. To address this, I designed a custom-made laparoscopic trainer featuring a moving camera, allowing trainees to simulate real surgical procedures effectively.

In 2009, through the Health Sector Development Programme, the College of Surgeons secured a World Bank grant that enabled the production of ten such trainers. To ensure cost-effectiveness without compromising quality, I personally oversaw their construction at home.

As President of the College of Surgeons of Sri Lanka in 2011, I played a key role in establishing the Skills Center at the college premises, which has since become a cornerstone of laparoscopic surgical training in the country. The center was constructed within just two months, made possible through generous donations and

collective efforts.
Upon its completion, Dr. David Tolley, then President of the Royal College of Surgeons of Edinburgh, who happened to be on holiday in Sri Lanka, attended the opening ceremony. His presence not only marked a significant milestone for the center but also strengthened the

longstanding ties between the two colleges. Since its inception in 2011, the Skills Center has consistently conducted regular training sessions, benefiting numerous surgical trainees. This initiative became widely known as the HOLT program (Hands-On Laparoscopic Training). In 2013, the Postgraduate Institute of Medicine made laparoscopic training mandatory for all trainee surgeons preparing for the MD Surgery exam. As a result, the college began conducting biannual workshops, each accommodating 20 trainees per session.

At this pivotal stage, B. Braun stepped forward in 2014 as a sponsor, supporting our training programs as part of their educational commitment. Their contribution included the provision of Aesculap hand instruments, significantly enhancing the quality and scope of the program.

2014 Basic Laparoscopic Training Workshop

However, by 2021, after a decade of continuous use, the TV screens in the trainers began to deteriorate, necessitating their replacement to maintain high-quality visuals for training. By 2024, after 13 years of extensive use, the trainers required significant refurbishment due to woodworm damage affecting their wooden components. In response, all ten trainers were reconstructed using durable and newly available PVC boards, ensuring enhanced longevity and improved usability.

This journey of pioneering, innovating, and sustaining laparoscopic training in Sri Lanka emphasizes the commitment to advancing surgical education and patient care. The continuous improvements and adaptations made to the trainers reflect the College of Surgeons' dedication to providing high-quality, cost-effective training solutions for future generations. With these enhancements, we ensure that laparoscopic surgery remains an integral part of Sri Lanka's medical landscape, accessible to all regions of the country.

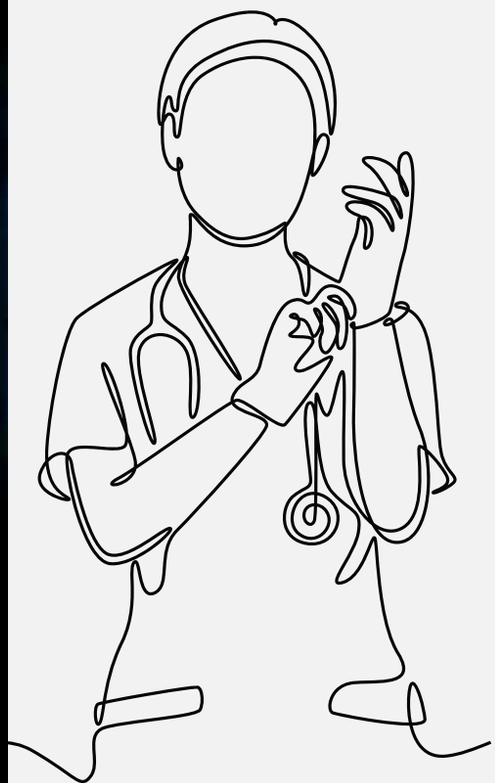
In the year 2014, Professor Bawantha Gamage established the "Sri Lanka Association of Minimally Access and Digital Surgeons" (SLAMAD) to bring all Laparoscopic surgeons under one organization. I was made a Patron of this prestigious organization, and I continue to work closely with them for the betterment of surgical training in Sri Lanka.

WOMEN'S CHAPTER

EMPOWERING WOMEN IN SURGERY

A STEP FORWARD IN SRI LANKA

Dr Minoli Joesph
MBBS, MD (Surgery),
MRCS (England)
Consultant Surgical Oncologist
CNTH



Introduction

Dr. May Ratnayake became the first Sri Lankan female surgeon in the early 20th century, serving at the Lady Ridgeway Hospital and Lady Havelock Hospital in Colombo. In 1942, she was elected President of the Ceylon Medical Association. Despite this promising early milestone and the recent surge in female enrollment in Sri Lankan medical schools, women remain significantly underrepresented in surgical specialties. This disparity is a global issue, with the ratio of male to female surgeons reaching as high as 8:1 in the United Kingdom. However, in Sri Lanka, the situation is even more pronounced, with female surgeons making up less than 10% of the field.

Is Surgery a Man's Job?

A common misconception is that surgery is a male-dominated field because women supposedly lack the physical and mental resilience required for the profession. However, a large-scale study by Wallis et al., published in JAMA Surgery, analyzed over 1,000,000 surgeries and found that procedures performed by female surgeons had lower post-operative complication and mortality rates than those performed by their male counterparts. This finding debunks the myth that surgery is inherently suited to men (1).

Another prevailing assumption is that women choose specialties with fewer on-call commitments due to family responsibilities. However, this is contradicted by the high representation of women in anesthesiology and pediatrics—two fields with intensive on-call requirements, sometimes even more demanding than surgery.

Overcoming Challenges

Role models and mentors play a crucial role in shaping postgraduate medical careers. The lack of female surgeons creates a vicious cycle, as fewer mentors discourage aspiring female surgeons from pursuing the specialty (2). Additionally, surgery is often stereotyped as a male domain in medical schools, leading to fewer opportunities for female students to gain hands-on experience and assist in surgical procedures (3).

One of Sri Lanka's key strengths is that entry into the postgraduate surgical training program is based on a transparent, competitive examination comprising a written component and a structured viva, minimizing gender-based discrimination. Nevertheless, very few female candidates opt to take the examination. Notably, almost all female trainees who enter the program successfully complete it, further demonstrating the absence of inherent gender-based barriers in training.

The Women in Surgery Subcommittee of the College of Surgeons of Sri Lanka

Provide a platform to identify, discuss, and address challenges faced by women in surgery.

Encourage, enable, and inspire female trainees and early-career surgeons to pursue surgical careers.

Identify factors deterring women from choosing surgery as a career.

Promote and support more women in entering the surgical field.

Collaborate and network with international surgical associations on issues related to women in surgery.

Established in 2022, the Women in Surgery Subcommittee, composed of all female members of the College of Surgeons of Sri Lanka, aims to:
The subcommittee was officially launched during a symposium on women in surgery at the Sri Lanka Surgical Congress in 2022.

> Despite this promising early milestone and the recent surge in female enrollment in Sri Lankan medical schools, women remain significantly underrepresented in surgical specialties.

Since then, membership has steadily grown, now including 30 members, including trainee surgeons. Through social media, the committee has fostered networking, shared insights, and engaged in discussions on surgical practice. Plans are underway to introduce a formal mentorship program for surgical trainees. Additionally, the committee has successfully conducted two outreach events ("roadshows") to promote surgery among female medical students at the Universities of Peradeniya and Ruhuna.

Conclusion

Although overt gender discrimination is minimal, the low number of women entering surgery as a postgraduate career highlights the need for urgent action. Dispelling myths about surgery—particularly during undergraduate training—and establishing formal mentorship and support systems for female surgical trainees are key steps in reversing this trend.

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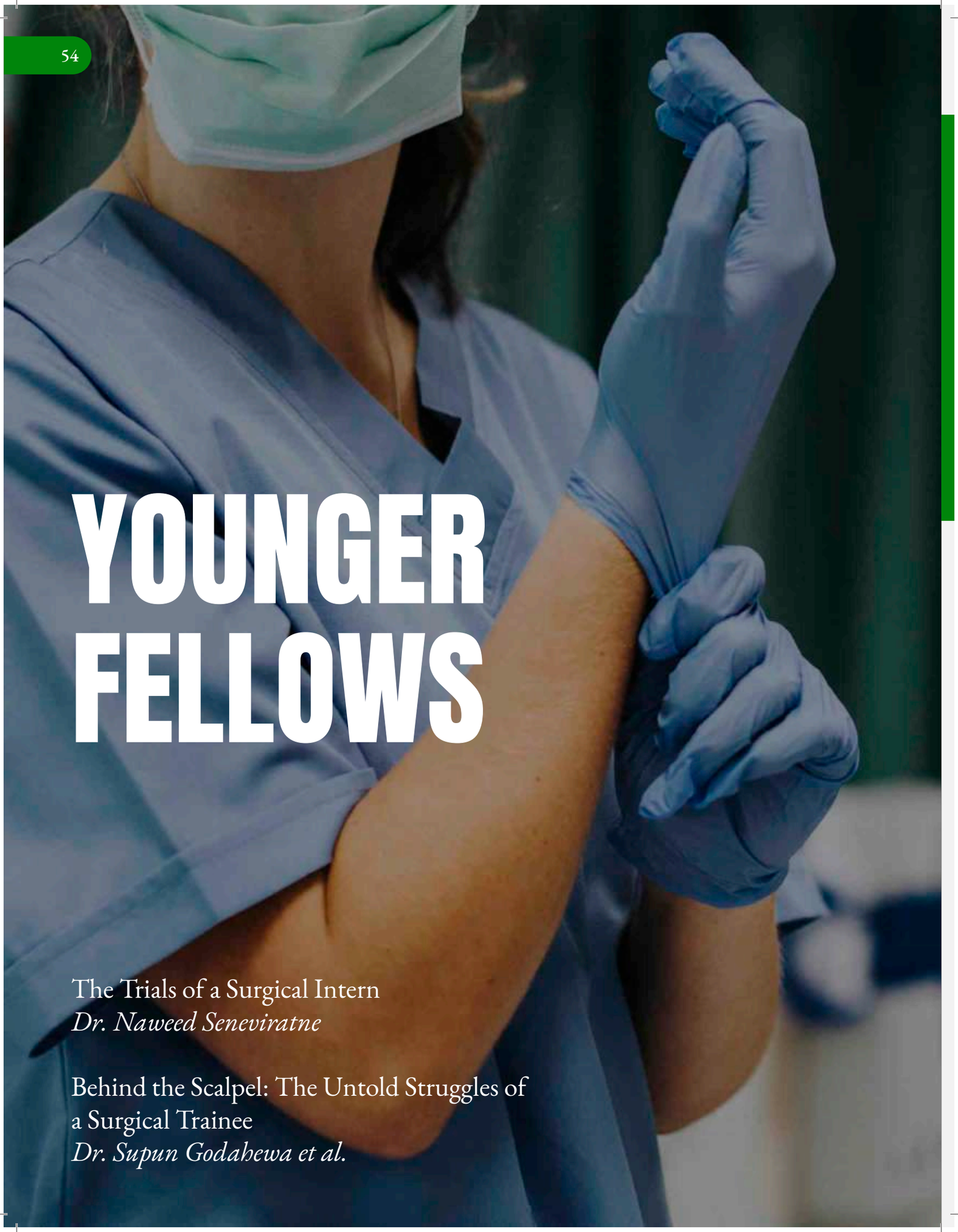
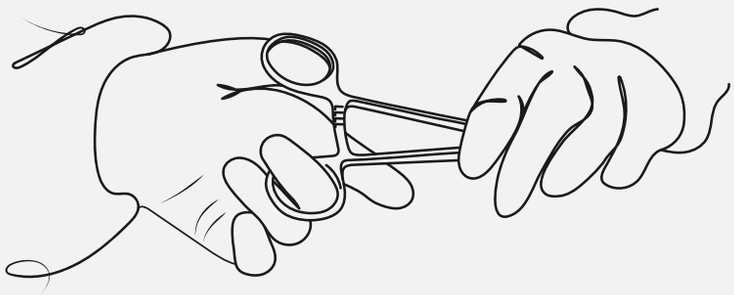


YOUNGER FELLOWS

The Trials of a Surgical Intern
Dr. Naweed Seneviratne

Behind the Scalpel: The Untold Struggles of a Surgical Trainee
Dr. Supun Godahewa et al.



THE TRIALS OF A SURGICAL INTERN

Naweed Senevirathne
MBBS (Rajarata)
Internship – NHSL (2024-25)
Currently – RHO SICU, NHSL

The eventful five-and-a-half-year journey as a medical student finally came to an end, marking the transition to an intern medical officer. Our first day at work was filled with both uncertainty and hope. One of the most common concerns echoed among us was, "I'll be a terrible doctor—I don't know enough." Senior doctors would reassure us with a simple, "You'll be alright," but their words often felt more like encouragement than genuine reassurance, making it difficult to fully believe them.

However, it was comforting to know that every medical professional had once stood in our shoes. I firmly believe that the starting point of a junior doctor in no way defines the final destination.

After being assigned to the surgical unit, I made my way through the unfamiliar surroundings, searching for the ward where I would spend the next six months. I had expected some sort of orientation—something akin to the structured introduction we received on our first day of medical school. Oh, how mistaken I was! The transition was as simple as placing my small backpack in the doctor's room and putting the stethoscope around my neck—and that was it. "Doctor, there are three admissions to clerk, ten discharges, and bed 10 is complaining of chest pain," a nursing officer called out. And just like that, The internship began.

> Every detail—from drug doses to referral letters, monitoring plans, fluid regimes, and performed procedures—had to be documented precisely and clearly.

Clerking patients initially took much longer than I had anticipated. Racking my brain to recall all the clinical scenarios I learned as a medical student proved challenging. Making the correct working diagnosis and deciding on a management plan gave me the oddly satisfying feeling that I was truly influencing a patient's outcome. Clerking was a major part of an intern's job, so it was inevitable that mistakes would occur. Every detail—from drug doses to referral letters, monitoring plans, fluid regimes, and performed procedures—had to be documented precisely and clearly. The surgeons, on the other hand, were swift and decisive, sometimes spending as little as ten seconds assessing a patient on a casualty day. At that pace, writing turned into scribbling, further reinforcing the age-old stereotype that doctors have terrible handwriting.

Daily rounds with the surgical team, led by the Consultant, were a ritual that never failed to highlight any faults or shortcomings in patient management. My surgical unit was steadfast in its commitment to practicing evidence-based medicine. For instance, the routine co-

prescription of an NSAID with a proton pump inhibitor was strictly forbidden unless there was a clear indication. Any deviation from this rule was swiftly met with our Consultant's signature reprimand: "We don't practice jungle medicine here." It took more than a few stern corrections for that lesson to truly sink in.

One of the most remarkable things was witnessing a senior surgeon's ability to diagnose with nothing more than a glance and palpation. The precision with which they could distinguish between acute appendicitis and ureteric colic left me in awe—it was almost always the correct diagnosis. Meanwhile, all I could confidently determine was whether the abdomen was soft or not. With time, the gap between the expertise of a senior doctor and an intern only seemed to sadly grow wider.

A surgical ward could only function smoothly with a skilled team of nursing officers—and I was fortunate to have the best. From the very beginning, they assisted with essential ward procedures like IV cannulation and urinary catheterization. The techniques they used during these procedures weren't found in any medical textbook; they came purely from experience. They constantly bombarded us with tasks—medication orders, investigation requests, radiology forms, and referrals—which, if I'm being honest, often got on my nerves. But at the end of an exhausting day, they were also the only ones who would make you a cup of tea, reminding me just how invaluable they truly were.

As the name suggests, the "theatre" was a spectacle, with surgeons as the performers. It was truly an art—one where skill, versatility, and strength were appreciated only by those who understood surgery. From the precision of an incision to the sawing of bone, every moment was mesmerizing to a junior doctor like me. Whenever I finished my ward work early,

One of the most remarkable things was witnessing a senior surgeon's ability to diagnose with nothing more than a glance and palpation.

I rushed to the theatre. On a lucky day, I might assist by merely suturing the skin with a simple interrupted suture—something I took great pride in. Mastering the palming of the needle holder, which improved dexterity, took time. Though it looked easy, it was not. As the theatre HO, meticulous preparation was essential for a smooth theatre day. It was frustrating when a patient had eaten just minutes before surgery because they were hungry—while we were used to going hours without food, some patients were not. Preparing the theatre list required senior approval days in advance. Initially, I would make mistakes, missing key cases, but over time, I learned which cases needed to be included. The moment my consultant asked, "What are the cases for today?" on the morning of a theatre day, and I could answer with certainty, was a true milestone.

As a junior doctor, I was naive to believe that all my patients could be saved. The one thing that never became easier with time was breaking bad news to patients and their loved ones. The common question, "Isn't there anything that can be done, doctor?" was often met with a long pause, followed by the reassurance that we would do our best to keep the patient comfortable. Resuscitation, which initially felt like pure chaos, soon became familiar territory—where I found myself leading the team, orchestrating every move. More often than not, patients didn't make it, but the rare, priceless moment of successfully reviving someone made it all worthwhile. I remember a senior consultant once saying, "Many patients will die throughout your career. If you can't handle that, choose another profession." So, I had to learn to accept it.

There were days when I struggled to find meaning in the work I was doing when I was on the brink of collapse. The only reason I kept going was the support of my selfless co-house officers. They were the ones who could truly empathize, as they were experiencing the same highs and lows. We always helped each other finish our work—it was never "mine" or "yours." What began with a few strangers working side by side ended in a camaraderie that I believe could never be broken.

Here I am, seated in a calm ICU as a Relief House Officer, reflecting on the whirlwind that was my internship. It feels almost surreal to think back on those days, wondering how we all managed to survive the relentless pace. The stress, the pressure, and the constant learning were intense, but somehow, we powered through it together. Now, as I sit here in this quieter environment, I realize just how much I miss those early days. Despite the exhaustion and the challenges, there was something uniquely fulfilling about it all. Looking back, it feels like those experiences, shaped me into the doctor I am today. The journey was tough, but I wouldn't change a thing.

There were days when I struggled to find meaning in the work I was doing when I was on the brink of collapse.

BEHIND THE SCALPEL: THE UNTOLD STRUGGLES OF A SURGICAL TRAINEE

Editors note – The topic was given by the SUTURE editorial team to the MD Surgery (2023 March) batch of students. The author shares a collective view point regarding the issue trainees face.

Supun Godahewa
MBBS (Colombo), MRCS, MD (Surgert) 2023 March | Senior Registrar in Vascular Surgery
Passionate about Cinema, Music and Surgical history

Pursuing a career in surgery is often portrayed as a noble and rewarding path—but the reality behind the operating room doors tells a different story. As surgical trainees, we face a unique constellation of challenges that test not just our medical knowledge, but our very humanity. While rewarding, this journey can feel isolating and overwhelming, leaving many to silently question their calling. Here, I offer an honest glimpse into the multifaceted struggles we endure both within and beyond the operating theater.

The Physical and Emotional Toll

In pursuit of learning

Surgical training demands extraordinary time commitments, often stationing us far from loved ones. The physical distance creates an emotional chasm that deepens with each missed child's birthday, family gathering, or friend's celebration. Personal hobbies—once sources of joy and balance—fade into memory as ward duties, night calls, and exam preparation consume our lives.

Over time, many trainees experience the unraveling of relationships: breakups become common, weddings are postponed indefinitely, and decisions around starting a family are repeatedly shelved. Some find themselves trapped in toxic dynamics they're too exhausted to navigate or leave. The emotional detachment required for survival in training often leads to a dangerous mislabeling—trainees are sometimes dismissed as "American Psychos," cold and without empathy when in reality, it's the coping mechanism of people stretched beyond their limits.

> The emotional detachment required for survival in training often leads to a dangerous mislabeling

The relentless schedule leaves little room for recovery. I still remember driving home after a 36-hour shift, jolting awake at the wheel during micro-sleeps on the expressway—a terrifying reminder of how fatigue endangers not just our patients, but ourselves.

The Mental Health Crisis Nobody Discusses

The emotional burden is perhaps the heaviest weight we carry. Watching patients suffer despite our best efforts, confronting our first major complication, or feeling inadequate in high-pressure moments—these experiences accumulate in our psyches with little outlet for processing.

I have been fortunate to access supportive mentors whenever I felt burnt out early in my career as a first-year registrar. Their guidance provided a crucial lifeline during my darkest moments to find that zest to keep on going. However, many of my colleagues weren't as lucky. Year after year, I witness talented surgeons-in-training struggle silently with their mental health, with some ultimately abandoning their surgical dreams altogether.

> Year after year, I witness talented surgeons-in-training struggle silently with their mental health, with some ultimately abandoning their surgical dreams altogether.

Yet in surgical culture, seeking help remains stigmatized. With limited access to confidential mental health services, many colleagues turn to unhealthy coping mechanisms = alcohol, emotional detachment, or worse, just to make it through another day. The surgical paradigm that equates vulnerability with weakness has created generations of surgeons who are technically brilliant but emotionally depleted.

A Culture That Needs Healing

Hierarchy and Humiliation

The surgical theater often doubles as a theater of intimidation. Workplace bullying manifests through public humiliation, belittling teaching methods, and microaggressions that erode confidence. Such cutting remarks, often delivered in front of patients or colleagues, exemplify the toxic teaching methods that continue to plague surgical education.

Competition among peers in this pressure-cooker environment further strains collegial relationships. Rather than fostering collaboration, the system sometimes pits trainee against trainee in a surgical Hunger Games where "may the odds be ever in your favor" becomes an unspoken mantra—a zero-sum game for opportunities, evaluations, and recognition, where only one can emerge victorious while others are left behind.

> **Who taught you how to suture??**
> **Dr. Dolittle or Dr. Dre?**
> **- Anonymous**

The Blame Game

When complications occur, as they inevitably will, the response often focuses on finding fault rather than fostering learning. Morbidity and mortality conferences, designed as educational forums, sometimes devolve into interrogations where trainees become scapegoats for systemic failures. These sessions shouldn't resemble a high-pressure political spectacle like Trump and J.D. Vance interviewing Zelensky, full of accusation and scrutiny. Instead, they should focus on constructive dialogue, root-cause analysis, and positive feedback, allowing trainees to learn and grow without fear of public shaming.

> **There is no such thing as a perfect operation–only a perfect response to an imperfect one.**
> **- Dr. Thomas Starzl**

Systemic and Practical Barriers

Financial Strain and Bureaucratic Hurdles

Despite working far beyond standard hours, many surgical trainees struggle financially. Unlike other medical paths, private practice options are often restricted during training. This financial pressure compounds when balanced against loans, travel costs, accommodation fees, and family responsibilities.

The bureaucratic machinery surrounding training often feels designed to frustrate rather than facilitate. Simple tasks—securing a leave day, processing a grade promotion, or even collecting a salary—become unnecessarily complex, consuming precious time better spent learning or resting.

> The bureaucratic machinery surrounding training often feels designed to frustrate rather than facilitate.

Inadequate Infrastructure and Training Structure

Many programs lack both physical infrastructure and educational architecture. After sleepless nights of saving lives, trainees often have nowhere to rest before the next shift begins. The absence of on-call accommodation is not merely an inconvenience—it's a patient safety issue.

> After sleepless nights of saving lives, trainees often have nowhere to rest before the next shift begins.

Similarly, the training itself often lacks clear objectives and consistent assessment. Many trainees often find themselves crowd-clearing tank cleaners rather than developing surgical expertise. Without structured mentorship, we navigate largely by instinct and peer advice, leading to anxiety, self-doubt, and uneven skill development.

Unique Challenges for Women in Surgery

The surgical landscape remains particularly challenging for women. From subtle exclusion—being asked to take notes rather than lead procedures—to more serious concerns like harassment, female trainees navigate additional layers of complexity.

The structural rigidity of training programs creates nearly impossible choices regarding pregnancy and parenthood. Maternity leave is often practically discouraged, and returning trainees face inflexible schedules and implicit questioning of their commitment. True gender equity requires not just policy reforms but a cultural shift where all trainees feel valued regardless of gender.

The Post-Qualification Quandary

Even after completing rigorous postgraduate training, challenges persist. Subspecialty opportunities remain limited, with rigid entry points that can waste years if missed. I still remember the dreaded feeling that haunted my final years of training—what if I have no choice but to practice in a subspecialty I don't enjoy for the rest of my life? This existential anxiety is a common thread among surgical trainees facing the bottleneck of limited fellowship positions and arbitrary selection timelines.

Those wishing to pivot get punished and must often restart from the beginning, losing momentum and enthusiasm in a system that values rigid adherence over adaptability. After investing a decade or more in surgical training, the prospect of being funneled into a career path by circumstance rather than passion represents a profound professional tragedy—one that the current system seems designed to perpetuate rather than prevent.

Humans, Not Machines

A persistent surgical mythology suggests that "you have to be tough to survive." But surgical trainees are not TAG Heuer watches—we do crack under pressure because we are human beings, not machines. The expectation of endless resilience against sleep deprivation, criticism, and emotional trauma isn't just unreasonable—it's dangerous.

Equally toxic is the rationalization: "We had it worse in our time, so you should too." This mindset perpetuates generational trauma rather than evolving toward healthier training environments. Repeating harmful practices isn't tradition—it's negligence.

> "We had it worse in our time, so you should too."

The Path Forward

The challenges surgical trainees face aren't merely personal hurdles—they reflect systemic problems requiring comprehensive solutions.

Reforms will be required at multiple levels. A more humane and understanding training culture, with access to mental health support, where taking leave isn't frowned upon, where there is zero tolerance and anti-bullying policies, and gender equality. Better compensation, a more structured training model where trainees select their subspecialty early, with focused training and clear assessment frameworks. Adapting such approaches could reduce frustration, improve efficiency, and foster greater mastery.

Sri Lankan trainees are blessed with an abundance of training and clinical material that possibly no other country offers. The sheer volume and variety of cases provide invaluable hands-on experience early in our careers. Our patients often displaying remarkable patience, resilience, and compliance become our greatest teachers, forgiving our learning curves and supporting our growth with quiet dignity.

Behind every successful surgeon stands the shadow of exceptional mentors. Despite the systemic challenges faced, some trainers silently support and wholeheartedly provide an incredible training experience, looking upon trainees as their children

The path forward requires acknowledging both the unique privileges and the very real struggles of surgical trainees. We need reforms that preserve what works well while addressing systemic failures. Our training environment should celebrate the exceptional clinical exposure we receive while simultaneously working to mitigate unnecessary hardships.

While resilience remains essential to surgery, we shouldn't confuse resilience with suffering in silence. Real change begins when institutions value not just the technical output of future surgeons—but their wholeness as human beings. As Winston Churchill reminds us, the true measure of a society lies in how it treats its most vulnerable members. In the surgical community, these are often the trainees who will one day lead the profession.

"Off the Scalpel"

Where Surgeons Escape (Because even the steadiest hands need a break from the OR—and possibly their in-laws)

Surgeons, there's more to you than the scalpel! "Off the Scalpel" is a space to share your interests, adventures, and creative pursuits outside medicine.

We know what you really do on your days off. Now's your chance to come clean—gloriously.

Calling All Surgeons Who Secretly Prefer Leopards to Laparoscopies!

What We Want From You:

Wildlife Escapades
- Let's face it: between the chaos of the OR and the "joy" of family debates over who forgot to pay the Wi-Fi bill, sometimes a surgeon's best therapy is disappearing into the wild.
- Birdwatching logs ("4 hours stationary = advanced focus training")

Mountain 'Conferences'
Convince your family that hiking Alagalla Peak is "professional networking"

Therapeutic Rants
"Why I'd rather face a wild boar than another mortality review"

Travel tales
Those exotic medical conferences or personal expeditions

Hobbies & passions
Photography, music, sports, or gourmet cooking, Thought-provoking reads
Books, articles, or podcasts that inspire you

Why Submit?

- Professional Development (...in creative work-life balance strategies)
- Mental Health Advocacy (Proving safari jeeps > spreadsheet stress)
- Community Bonding (Find fellow surgeons who also measure time in bird migrations rather than clinic hours)
- Personal Glory (Finally justify that 20GB of leopard photos as "academic material")

Disclaimer: All "jungle research" submissions will be treated with the confidentiality they deserve. No spouses will be notified.

P.S. Top entries receive:
Undying colleague respect
An alibi for your next "academic retreat"
The joy of seeing your hobby called "professional development"

#DID YOU KNOW?

Interesting Facts

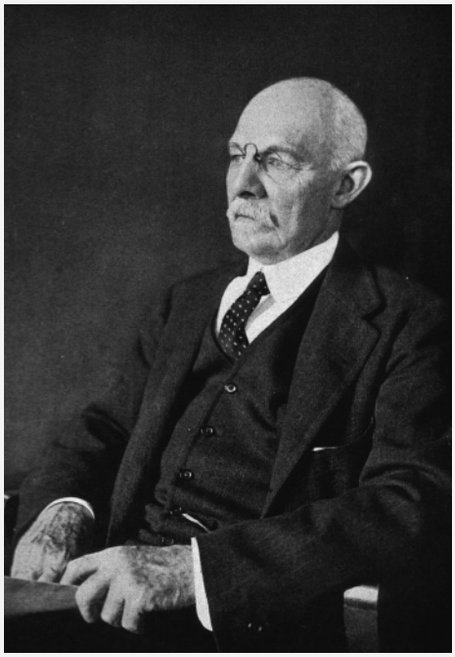
The segement is contributed to the SUTURE by
Dr. Kanchana Wijesinghe
Senior Lecturer in Surgery
Department of Surgery
University of Sri Jayawardenapura

GLOVES OF LOVE

The story of how surgical gloves were first invented is a fascinating blend of medical necessity, personal devotion, and scientific progress. It begins

Following the work of Joseph Lister, who popularized aseptic surgery in the 1860s and 1870s, it was insisted that surgeons and nurses wash their hands in carbolic acid. However, this was far from perfect—post-operative infections were still common. At Johns Hopkins Hospital in Baltimore, USA,a brilliant but demanding surgeon named Dr. William Stewart Halsted had surgeons and nurses wash their hands with soap, then a solution of potassium permanganate, a hot oxalic acid bath, and a mercury chloride compound.

Dr. Halstead worked often with a nurse named Caroline Hampton, who he praised as "unusually efficient: during operations. Caroline was an exceptional surgical nurse, but she had a serious problem—her hands were highly sensitive to the mercury-based antiseptics (like mercuric chloride) used in surgery.



Dr. William Stewart Halsted in 1922

Caroline Hampton in 1889

Dr.Halsted's first operation in the New Surgical Amphitheatre in 1904

The chemicals caused severe dermatitis, making it painful for her to assist in operations. One day Caroline went to see him and said “Dr. Halstead I cant work anymore, my hands are so raw I’,m resigning.”

Seeing her distress, Dr.Halsted sought a solution to protect her hands without compromising surgical precision. In 1889, Halsted approached the Goodyear Rubber Company (known for rubber products) and commissioned thin rubber gloves specifically designed to shield Caroline’s hands from the irritating chemicals. The early versions were essentially custom-fitted rubber gloves, sterilized before use.

To Halsted’s delight, the gloves worked perfectly—Caroline’s skin healed, and she could assist in surgeries without pain. William Stewart Halstead and Caroline Hampton were married soon after he gave the gloves.

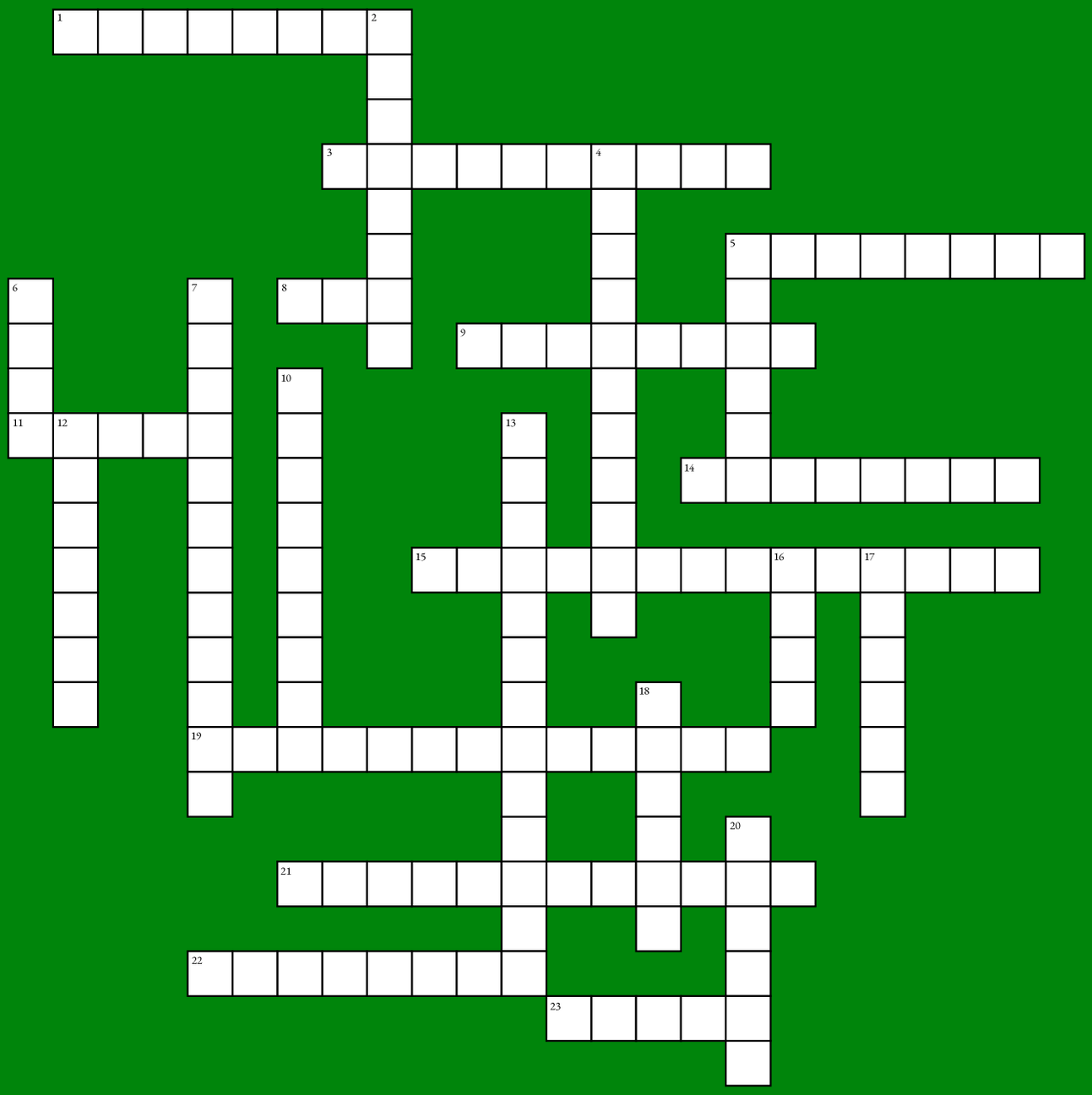
By the 1890s, as germ theory became widely accepted, the use of sterilized rubber gloves became standard practice. The modern surgical glove—now made from latex, nitrile, or other materials—evolved from Halsted’s original design.

What began as a romantic gesture between Halsted and Caroline turned into one of the most important advancements in medical history.

So, the next time you see a surgeon putting on gloves, remember—it all started because a brilliant doctor wanted to protect the woman he loved.

First Surgical Glove

THE SURGEONS' CROSSWORD



Across

1. An anesthetist who developed a retractor (that is fixed to the bedrail) while observing his surgical colleagu struggling to secure a drape (8)
3. Surgical opening of the skull (9)
5. Performed the first successful gastrectomy (8)
8. A modern diagnostic device invented by Raymond Damadian (3)
9. Tumor destruction via radiofrequency or cryo (8)
11. The ancient Egyptian text that contains some of the earliest surgical techniques (5)
14. Ancient Indian system of holistic health" or "Traditional Indian medicine (8)
15. The study of tissues obtained from surgery for diagnostic purposes. (12)
19. Surgical removal of a butterfly-shaped gland (13)
21. A minimally invasive surgical technique using a camera and small incisions (12)
22. A type of surgical pathology involving the study of tumors (8)
23. The man behind fundoplication (6)

Down

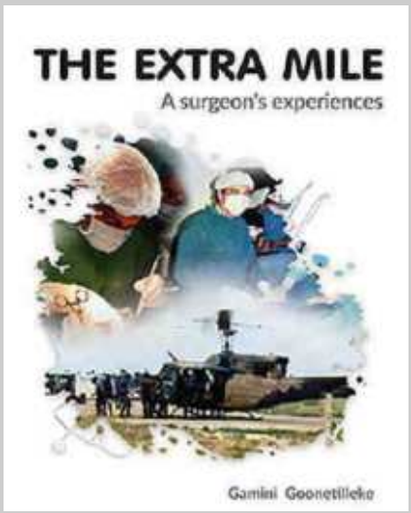
2. A surgical pathology term for the death of tissue due to lack of blood supply. (8)
4. A historical surgical procedure to treat migraines by drilling holes in the skull (11)
5. Taking a piece of tissue (6)
6. French barber-surgeon who tied arteries instead of cautery (4)
7. Surgical repair of a protruding organ (12)
10. Surgical removal of a lung lobe (9)
12. A robotic-assisted surgical system used for precision procedures (7)
13. A surgical procedure to remove the prostate gland (13)
16. A modern surgical technique using high-frequency sound waves to break up tissue (4)
17. The father of modern surgery who pioneered antiseptic techniques (6)
18. The first surgeon to use ether as an anesthetic in 1846 (6)
20. The first successful organ transplant was performed in 1954 (6)

Crossword Answers - page 73

Letters to the EDITORS

GAMINI GOONETILLEKE'S WIDE-RANGING MEDICAL WORK IN SRI LANKA

"In the Line of Duty: The Life and Times of a Surgeon in War and Peace"
a memoir published in 2008.



"The Extra Mile: A Surgeon's Experiences" provides a selective, poignant, and representative view of my surgical experiences, especially on the war front. The book offers detailed insights into surgical procedures complemented by rare photographs and illustrations.

Published in 2022, Glossy paperback with 228 pages and 350 color photographs & illustrations.

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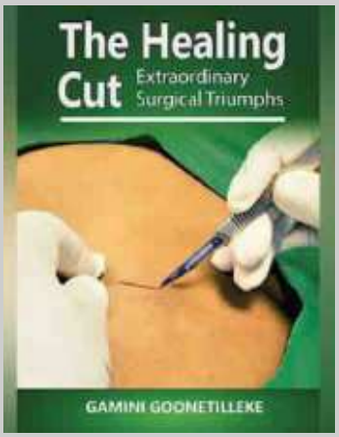
Bookshop Price Rs 3000/=



"The Healing Cut: Extraordinary Surgical Triumphs" is a compendium born from four decades of firsthand surgical experiences relating to almost all branches of surgery in hospitals across Sri Lanka. Delving into the management of uncommon and exceptional cases, this book offers invaluable insights for all health professionals, medical students, doctors, and postgraduate trainees and consultants irrespective of their specialty seeking to expand their clinical repertoire beyond conventional textbooks. The book is also written with the general readers in mind and offers them a panoramic insight into the challenges faced by a surgeon and the surgical support provided in life-threatening situations.

Published -2024, glossy paperback with 192 pages and over 310 color photographs and illustrations.

ISBN 978-624-99167-1-5
Bookshop Price Rs 3250/=

Contact 0777 794 107 or email: doctorgamini@gmail.com

THE NEED FOR A LUNG CANCER SCREENING PROGRAM IN SRI LANKA

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Senior Registrar in Thoracic Surgery at the National Hospital for Respiratory Diseases, Sri Lanka.
MD(Surgery) 2024 May
Special interest in thoracic oncology and minimally invasive surgery.
Research focus - lung cancer screening and improving surgical outcomes in low-resource settings.

Lung cancer remains one of the most significant public health challenges worldwide, and Sri Lanka is no exception. According to the National Cancer Registry, lung cancer was the second most common cancer in men and the tenth most common in women in 2021, with 2,091 new cases diagnosed. Furthermore, data from 2019 revealed 1460 deaths related to lung cancer, giving it the highest crude death rate of 6.7 among all cancers in the country(1). Despite this alarming burden, Sri Lanka currently lacks a dedicated lung cancer screening program.

Early detection of lung cancer significantly improves survival rates. The National Hospital for Respiratory Diseases (NHRD), the only dedicated thoracic center in Sri Lanka, performed just 200 lung resections in 2021, thus highlighting the severe underutilization of surgical intervention due to late-stage diagnosis. Most cases present in advanced stages, limiting treatment options and resulting in poor prognoses(2). A structured screening program could shift this trend by identifying high-risk individuals before the development of symptoms, allowing for timely intervention.

The implementation of lung cancer screening programs in high-income countries has demonstrated a marked reduction in mortality. The National Lung Screening Trial (NLST) in the United States showed a 20% decrease in lung cancer-related deaths through low-dose computed tomography (LDCT) screening in high-risk populations(3). The NELSON trial in Europe further confirmed that LDCT screening can reduce lung cancer mortality by up to 26% in men and 39% in women(4). Given these findings, establishing a similar program in Sri Lanka could significantly impact lung cancer outcomes.

A national lung cancer screening program should focus on high-risk groups, primarily individuals aged 55–75 years, based on local epidemiological data. According to 2021 statistics, the incidence of lung cancer per 100,000 population in males was 16 between the 50 – 55 age group, increasing to 38 in 55–60, 71 in 60–65, 110 in 65–70, and 135 in 70–75. In females, the incidence was 12 per 100,000 in ages 55–60 and increased to 22 in 60–65. This trend highlights the sharp rise in incidence after 55 years of age, supporting the rationale for

The National Lung Screening Trial (NLST) in the United States showed a 20% decrease in lung cancer-related deaths through low-dose computed tomography (LDCT) screening in high-risk populations(3). The NELSON trial in Europe further confirmed that LDCT screening can reduce lung cancer mortality by up to 26% in men and 39% in women(4).

setting the lower age cutoff for screening at 55 years(1). Implementing screening within this age range would allow for early detection when intervention is most effective.

In addition to determining the appropriate age group for screening, it is crucial to identify the region to initiate a pilot program. The highest number of lung cancer cases were reported from the Colombo district, with 178 cases in males and 62 in females. However, the highest crude rate for males (25.7) was recorded in the Polonnaruwa district, while the highest crude rate for females (4.9) was reported in the Colombo district. These findings suggest that Colombo, with its high patient volume, would serve as an ideal urban center for screening implementation, while Polonnaruwa should be considered for targeted rural and regional pilot programs(1). By prioritizing these areas, the screening initiative can be tailored to regions with the greatest disease burden, maximizing its impact.

The economic burden of lung cancer In Sri Lanka Is considerable(5). A 2015 study estimated that tobacco-related cancers, including lung cancer, cost the country approximately US$121.2 million per year in which lung cancers directly cost around US$ 9.8 million and indirectly cost around US$ 22.3 million. Direct medical costs, such as hospitalizations and treatments, contributed significantly, while indirect costs, such as lost productivity due to illness and premature death, accounted for about 65% of the total economic impact. Given that lung cancer is a major contributor to tobacco-related diseases, its financial strain on the healthcare system and economy is substantial. The absence of a structured lung cancer screening program exacerbates this burden, as late-stage diagnoses lead to more intensive and costly treatments. Implementing an effective screening program could facilitate earlier detection, potentially reducing both the human and economic toll of the disease.

Collaboration between government health authorities, the College of Surgeons of Sri Lanka, respiratory specialists, and oncologists is essential to designing an effective screening strategy. Additionally, raising public awareness and educating primary care physicians on early detection strategies can complement a structured screening initiative.

Implementation challenges include resource constraints, infrastructure limitations, and the need for trained personnel. However, a phased approach incorporating pilot programs in high-risk regions, followed by gradual expansion, could make such a program feasible. Collaboration between government health authorities, the College of Surgeons of Sri Lanka, respiratory specialists, and oncologists is essential to designing an effective screening strategy. Additionally, raising public awareness and educating primary care physicians on early detection strategies can complement a structured screening initiative.

Financial investment in lung cancer screening may seem substantial, but the long-term benefits outweigh the costs. Early-stage lung cancer treatment is significantly less expensive than managing advanced disease. Moreover, improved survival rates translate to a healthier workforce and reduced economic burden on families and the healthcare system.

In conclusion, Sri Lanka faces a growing lung cancer burden, with high mortality rates due to late diagnosis(6). The lack of a structured screening program contributes to poor outcomes, emphasizing the urgent need for national intervention. Evidence from global trials underscores the effectiveness of LDCT screening in reducing lung cancer deaths, making its introduction in Sri Lanka a critical priority. With strategic planning, stakeholder collaboration, and phased implementation, a national lung cancer screening program could save lives and improve overall cancer care in Sri Lanka.

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CHALLENGES AND OUTCOME OF MINIMALLY INVASIVE ESOPHAGECTOMY AT A GRADE A BASE HOSPITAL IN SRI LANKA

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Consultant General Surgeon
Base hospital Mahiyanganya

Esophageal cancer is ranked the sixth cause of cancer-related death in the world. In. Sri Lanka, it's the fourth most common cancer amongst males and 7th among females and is the second leading cause of cancer-related mortality.

Conventional open oesophagectomy with right thoracotomy and upper midline laparotomy is associated with increased mortality rates largely due to the associated pulmonary complications, requiring prolonged ICU and ward stays.

The application of minimally invasive oesophagectomy and improved neoadjuvant treatment strategies has resulted in a significant improvement in mortality and morbidity.

Minimally invasive esophagectomy has become popular in Sri Lanka during the past few years however, these are mainly performed at tertiary/teaching hospitals.

I present a series of Minimally invasive esophagectomies done at Base Hospital, Dickoya (BHD). BHD is a grade A base hospital which is situated in Nuwara-eliya district and serves nearly five hundred thousand population. It has a three-bed ICU, two-bed theatre, and an endoscopy unit served by one general surgeon and one consultant anesthetist.

Ten minimally invasive esophagectomies were performed from April 2023 to February 2024. Male (5) and female (5) with a mean age of 59.3 years. The majority were ASA II (5/10); were operated upfront without neoadjuvant treatment (6/10) and had a cervical anastomosis (9/10).

Average blood loss was 310ml and the duration of surgery was 290min. One patient required conversion to open surgery because he did not tolerate one-lung ventilation during surgery.

One patient died on postoperative day 3 due to pneumonia and the remainder recovered without significant complications, except for one who developed a salivary fistula in the neck which healed spontaneously. The mean ICU stay was 3.2 days and the mean hospital stay was 10.3 days. One patient developed an anastomotic stricture at post-operative 12 weeks and required endoscopic dilatation. Long-term outcomes are being audited and will be presented in a subsequent edition.

Challenges

Delay in diagnosis

Most of the patients on diagnosis had advanced disease. Several factors contributed to this.

1. Most of the patients in this region were from poor socio-economic backgrounds with poor health literacy. They present late.

2. We had no dedicated pathology services. Specimens of biopsies and resection samples were sent to District Base Hospital Theldeniya for processing and then sent to Sirimavo Bandaranayake Specialised Children Hospital, Peradeniya for reporting. This process takes minimally one month to obtain a histopathological diagnosis.

3. Difficulty in getting a timely CT scan. Even though BHD has a radiology department with a consultant radiologist, facilities for CT scans are not available. CT scans were done at District General Hospital, Nuwara Eliya on a quota of 5 routine CT scans per week. Waiting time for CT scans is approximately 4-6 weeks.

Preoperative preparation

Many essential preoperative elements in patient optimization were not available at BHD. We did not have a nutrition service at BHD. The patients were sent to DGH Nuwaraliya for nutrition assessment and optimization. 2D Echocardiograms and lung function tests are essential preoperative investigations for esophagectomies irrespective of patients' cardio-pulmonary status. Both these were done by sending patients to DGH Nuwara-eliya.

Setting up the theatre and equipment

Minimally invasive (Thoraco laparoscopic) esophagectomy was done for the first time at BHD. Double-lumen endotracheal tubes, accessories for positioning patients, endo GIA staplers, and locking vessel clips (Hem-o-lok) were not available. Also, the monthly supply of carbon dioxide for insufflation was inadequate to perform major laparoscopic surgeries. With the help of administration, double-lumen endotracheal tubes and an adequate supply of carbon dioxide were addressed, but not the rest.

Intraoperative challenges and modifications

Though minor and intermediate general surgical and gynecological laparoscopic surgeries were ongoing, the theatre staff was not familiar with an entirely new major procedure, especially the thoracoscopy part. Assisting medical officers were not comfortable with operating the 300 cameras for thoracoscopy. Through the learning curve for thoracoscopy, they gained confidence.

Thoracoscopy is done in the lateral or prone position. The prone position has the advantage of getting a larger space to operate. This is because the collapsed lung falls to the anterior chest wall which allows better access to the posterior mediastinum. The disadvantage of a prone position is the inability to convert to open without changing the position to lateral or supine in case of an emergency where rapid conversion is required. However, all thoracoscopies were done in the prone position.

The unavailability of accessories for prone positioning was a huge challenge in positioning the patient in the prone

Challenges

position. Without a prone headrest, it is difficult to position, especially with a double lumen... ...endotracheal. We had to use several head rings and turn the head to a side to protect the double lumen tube. Pillows were used to rest the chest and the pelvis preventing excessive pressure on the abdomen.

Thoracoscopic mobilization of the esophagus was done with a vessel-sealing device (Ligasure). The azygous vein is usually clipped with locking vessel clips such as Hem-o-lok. Since the unavailability of these clips azygous vein was ligated with 2 0 vicryl. The arching segment of azygous is very short ligatures are prone to slip off. To prevent slipping of the suture ordinary titanium clips were applied once the vein collapsed after applying sutures. Application of titanium clips without ligating the vein is difficult since the length of the clips is inadequate when the vein is filled, and it tends to tear the vein. The same technique was applied to the left gastric vessels during the laparoscopic dissection.

Due to the unavailability of endo GIA staplers, an additional left subcostal incision was performed to create gastric conduit in patients with bulky tumors and who have relatively short stomachs that could not delivered to the neck for extraction. In three patients it was possible to do single incision surgery with cervical extraction. However, in these three cases, the mobilized stomach was gently pulled up to the neck, and the division of the stomach was at the neck between soft bowel clamps. Completion of the gastric conduit was with sutures.

Postoperative care is of paramount importance in any surgery. When considering esophagectomy postoperative care has a pivotal role mainly aimed at preventing pulmonary complications and rehabilitating nutritional status. Despite the inadequacy of physiotherapists and the unavailability of TPN and nutrition supplements, these goals were achieved.

Discussion

Minimally invasive thoraco-laparoscopic esophagectomy has gained popularity in last two decades and it is becoming popular in Sri Lanka as well. Laparoscopy-trained surgeons are working at remote hospitals with poor resources. Underutilization of their skills due to unavailability and maldistribution of resources is a major issue. Developing a cluster system with access for regional surgeons would be beneficial for both surgeons and patients.

Considering the demography of this region, most of the population is from a poor socioeconomic background. Most of these patients are estate laborers. The next accessible tertiary hospitals for these patients are DGH Nuwara-eliya which is 45km away and National Hospital Kandy 71km away. Also, the public transport and infrastructure of roads in this area is suboptimum. Traveling to these hospitals is an additional economic burden for these patients. Even a general surgical unit is well established here uplifting the facilities for major open and laparoscopic surgeries is beneficial to the region.

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SCRUB IN *for laughs*

A woman was obsessed with plastic surgery...

Her doc told her a new procedure had been developed- they put a knob on the back of your neck and every time you see a wrinkle, turn it one click to the right and the wrinkle will disappear. She came in right away and had the procedure done.

A few weeks later, she was having some issues and visited her doc. "What's wrong, ma'am?" he said. "Well, I now have these huge bags under my eyes." said the woman. The doctor replied, "Ma'am, those aren't bags. Those are your breasts." "Oh!" said the woman, dumbfounded. "What was your other issue?" asked the doctor. The woman paused for a moment, then said, "Well, never mind. That explains the goatee."

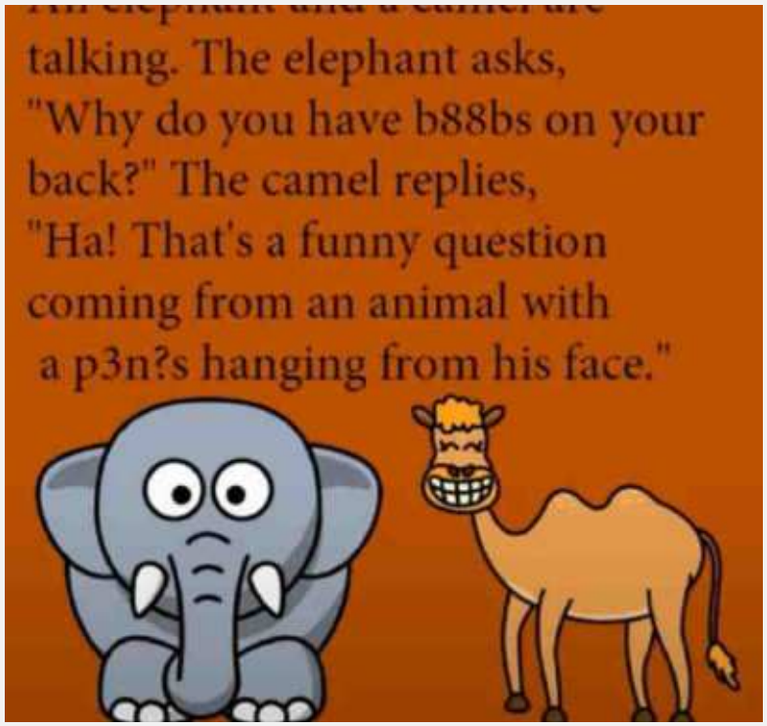
A surgeon is about to perform his first surgery...

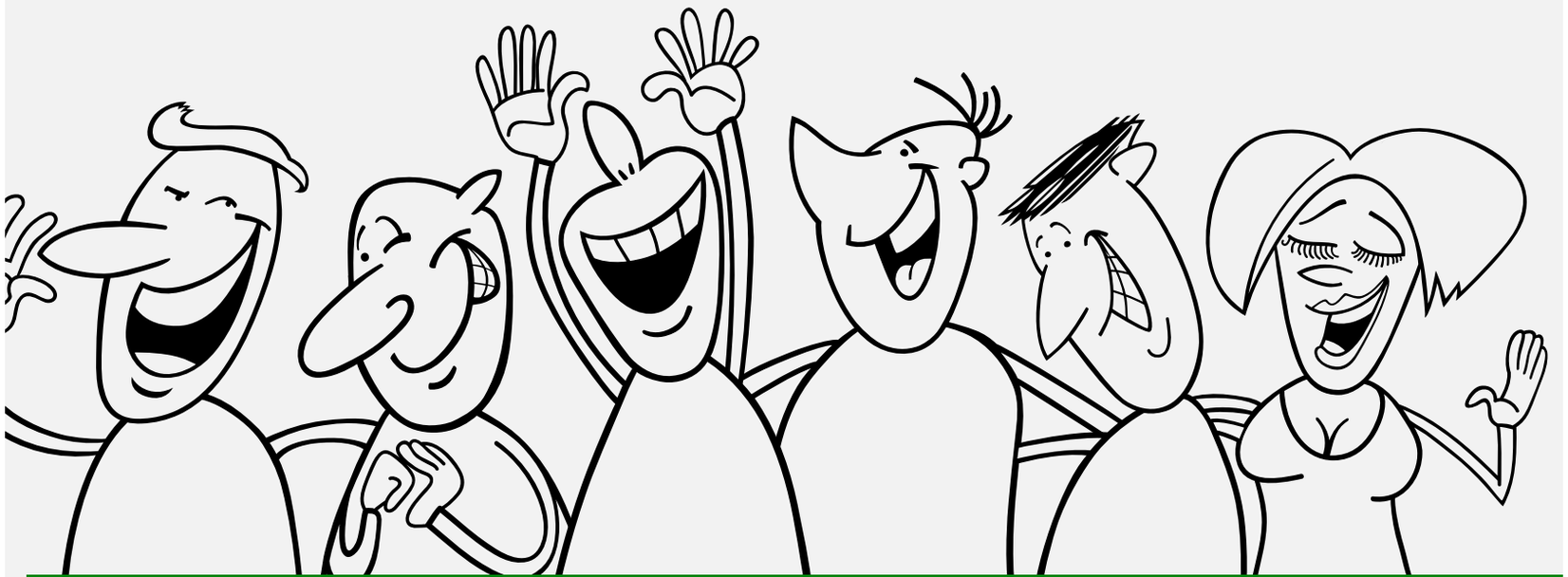
...and the patient is lying on the surgical table, waiting for the anesthetist. The doctor grabs the patient's hand and takes a deep breath.

Surgeon: "Don't worry, Richard, this is not a big deal, just a few cuts here and there, and all done in less than an hour. Tonight you rest, watch the game, and forget about this."

Patient: "My name is not Richard!"

Surgeon: "Oh, I'm just talking to myself."





Crossword Answers (from pagee 64)

Across

1. Thompson
3. Craniotomy
5. Billroth
8. MRI
9. Ablation
11. Edwin
14. Ayurveda
15. Histopathology
19. Thyroidectomy
21. Laparoscopic
22. Oncology
23. Nissen

Down

2. Necrosis
4. Trepanation
5. Biopsy
6. Pare
7. Hernioplasty
10. Lobectomy
12. Davinci
13. Prostatectomy
16. HIFU
17. Lister
18. Morton
20. Kidney

Announcements

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Contents

Smith+Nephew

T.I.M.E. clinical decision support tool

Use MolecuLight *i*.X™ wound assessment tool to measure wound surface area and evaluate bioburden level

Assess patient, wellbeing and wound

Establish diagnosis and baseline characteristics for appropriate support and comorbidities that may impact healing. Record wound type, location, size, wound bed condition, signs of infection / inflammation, pain location and intensity, comorbidities, adherence / concordance to treatment

Bring in multi-disciplinary team and informal carers to promote holistic patient care

Record referral to others such as surgical team, wound specialist nurse, dietician, pain team, vascular and diabetes team, podiatrist, physiotherapist, family carers and trained counsellor

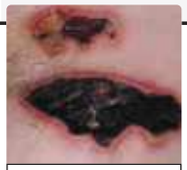
Control or treat underlying causes and barriers to wound healing

Record management plan for: systemic infection, diabetes, nutritional problems, oedema, continence, mobility, vascular issues, pain, stress, anxiety, non-adherence / concordance with offloading and compression, lifestyle choices

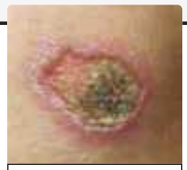
Decide appropriate treatment

T — Tissue non-viable[1-2]

1. IDENTIFY THE BARRIERS TO WOUND HEALING



Necrotic



Slough

2. SELECT PRIMARY & SECONDARY INTERVENTIONS

Debridement

Hydrogel*

Deslougher*

INTRASITE◊ GEL or INTRASITE CONFORMABLE

IODOFLEX◊ or IODOSORB◊ Range

3. WOUND MANAGEMENT OUTCOME

Viable healthy wound bed

I — Infection and / or Inflammation[1-2]

1. IDENTIFY THE BARRIERS TO WOUND HEALING

Infected

Deep infected cavity wound

Suspected biofilm

2. SELECT PRIMARY & SECONDARY INTERVENTIONS

Manage bioburden

Antimicrobial*

ACTICOAT◊ Range

DURAFIBER◊ Ag

IODOFLEX or IODOSORB Range

3. WOUND MANAGEMENT OUTCOME

Non-inflamed, non-infected wound

M — Moisture imbalance[1-2]

1. IDENTIFY THE BARRIERS TO WOUND HEALING

Dry

💧 | 💧💧

💧💧💧

2. SELECT PRIMARY & SECONDARY INTERVENTIONS

Restore moisture balance

Hydrogel*

Foam , gelling fibre or NPWT†

INTRASITE GEL or INTRASITE CONFORMABLE

ALLEVYN◊ GENTLE BORDER, ALLEVYN GENTLE, DURAFIBER or PICO◊‡

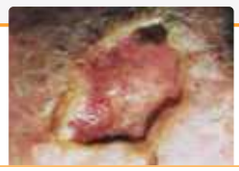
ALLEVYN LIFE, ALLEVYN LIFE NON-BORDERED, DURAFIBER or RENASYS◊

3. WOUND MANAGEMENT OUTCOME

Optimal moisture balance

E — Edge of wound non-advancing[1-2]

1. IDENTIFY THE BARRIERS TO WOUND HEALING



Non-advancing or abnormal wound edge

2. SELECT PRIMARY & SECONDARY INTERVENTIONS

Promote epithelialisation and healthy periwound skin

NPWT and skin care

PICO or RENASYS SECURA◊ / PROSHIELD◊ Range§

3. WOUND MANAGEMENT OUTCOME

Advancing edge of wound

*Use appropriate secondary dressing as per your local protocol; †NPWT: Negative Pressure Wound Therapy; ‡Level of exudate for wounds suitable for NPWT.

Evaluate and reassess the treatment and wound management outcomes

Evaluate: Record wound progression within given timelines. **Flag** if no change, go back to A, B, C and change treatment where indicated

Developed with the support of Glenn Smith[3] and Moore *et al.* 2019[4]

§SECURA Range includes SECURA Moisturising Cleanser, SECURA Total Body Foam, SECURA Dimethicone Protectant, SECURA Extra Protective Cream, No Sting Skin Prep; PROSHIELD Range includes PROSHIELD Plus and PROSHIELD Foam and Spray; ‡ALLEVYN Range includes ALLEVYN LIFE, ALLEVYN GENTLE BORDER and ALLEVYN GENTLE BORDER LITE.

Reference: 1. Schultz GS, Sibbald RG, Falanga V, *et al.* Wound bed preparation: a systematic approach to wound management. *Wound Rep Reg* (2003);11:1-28. **2.** Leaper DJ, Schultz G, Carville K, Fletcher J, Swanson T, Drake R. Extending the TIME concept: what have we learned in the past 10 years? *Int Wound J* 2012; 9 (Suppl. 2):1–19. **3.** Smith G, Greenwood M, Searle R. Ward nurse's use of wound dressings before and after a bespoke educational programme. *Journal of Wound Care* 2010, vol 19, no.9. **4.** Moore Z, Dowsett C, Smith G, *et al.* TIME CDST: an updated tool to address the current challenges in wound care. *Journal of Wound Care*, vol 28, no 3, March 2019: 154-161.

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SUTURE