SUTURE

2023-01

NEWSLETTER OF THE COLLEGE OF SURGEONS OF SRI LANKA

"Binding Surgeons Togethe

Inside this issue

THE COLLEGE OF SURGEONS OF SRI LANKA

No. 6, Independence Avenue, Colombo 07
Tel : 011 2682290/ Email: collsurg@gmail.com, Website : www.surgeons.lk
SUTURE Editors : Dulantha De Silva & Gayan Ekanayake

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President's address

Past President Dr Satish Goonesinghe,
Chief Guest Vidya Jyothi Emeritus Professor Rohan Jayasekara,
Guests of honour Vidya Jyothi Emeritus Professor Janaka de Silva,
Senior cardiothoracic surgeon Dr.Chandima Amarasena,
Vice Chancellor Professor HD Karunaratne,
Dean FoM Vidya Jyothi Professor Vajira Dissanayake,
Deputy Director General of Health Services and the Director of the National Hospital of Sri Lanka, Dr Kumara Wickremasinghe,
Director PGIM Professor Senaka Rajapakse,
Council members,
Distinguished guests,
Colleagues and friends,

I accept the honour of being inducted as the President of the College of Surgeons of Sri Lanka with great humility and pride. Having served the College for almost 21 years since 1991, in various capacities such as, a Council member, Assistant Treasurer, Secretary, Vice President and President Elect, I consider holding this high office a privilege and pledge to serve the college to the best of my ability.

Ladies and gentlemen, I have been an academic, a trainer and a researcher since 1995 and therefore the subject I chose to speak on today is "Training the Future Surgeon" which is very close to my heart. The training of a surgeon has come a long-way and has changed in leaps and bounds since we were trainees. Training in the past was mainly a period of apprenticeship under many senior surgeons, often with minimal supervision. There were no regular assessments, no workshops to update knowledge nor any assigned tutors to meet and discuss our concerns. The conduct of examinations was also largely without much oversight. To be honest, several examiners came to the scrutiny board with an essay question written on a piece of paper to be typed by the clerk. There was no or minimal scrutiny and discussion of the questions, nor a model answer was provided. There was a general reticence to question the senior surgeons who ran the examination.

Vivas were no better, questions varied between candidates ranging from very simple to extremely difficult scenarios at times, probably reflecting the mood of the examiner. However, the situation has improved remarkably over the past especially under the past Director of the PGIM, Professor Janaka de Silva and the current Director Professor Senaka Rajapakse. Under their direction, many processes were reformed, notable amongst them were monitoring and post examination counselling.

Currently, theory examiners meet on the day before or the day of the exam, submit their questions and model answers for scrutiny and moderation, by the full panel of theory examiners. There is also uniformity in the questions asked from candidates at viva boards. The award of marks is based on predetermined marking descriptors. Any significant discrepancy and inter-examiner variation in the award of marks is reviewed by the chief examiner and respective examiners during the examination. Furthermore, the performance and conduct of all examiners is independently assessed by two accredited external assessors, i.e. one Sri Lankan and one from the Royal College of Surgeons of Glasgow and their reports given confidentially to each examiner.

Immediately after the examination, each candidate is given a feedback form on each day of the exam to state anonymously, any concerns regarding the exam or examiners they faced on that day. These comments are looked at by the Director, PGIM and the Chief examiner only and any action deemed necessary is taken before releasing results or where necessary afterwards. Therefore, these checks and balances have led to a much more objective and fair examination process in postgraduate surgery exams compared to the past.

In addition, trainees now have regular assessments, compulsory workshops to update their knowledge and skills as well. Also, each teaching hospital has a designated Surgical Tutor with whom they can discuss their concerns regarding their training, personal problems and the problems they face with their trainers. Therefore, MD Surgery examination has received the recognition of the Royal College of Surgeons of Glasgow in the UK and the candidates who pass the MD Surgery examination, receive the Member of the Royal College of Surgeons of Glasgow diploma (MRCS-Glasgow) without examination and are eligible for direct registration in the General Medical Council in the United Kingdom. This enables them to apply for fully paid training fellowships in the UK for their mandatory overseas training.

Ladies and gentlemen, coming to my topic of the day, "Training the Future Surgeon", we must first answer the question, who is the future surgeon?. The landscape of surgical practice is changing rapidly. Not too long ago, artificial intelligence and robotic surgery were figments of our imagination, portrayed in science fiction. Today they are amongst the fastest growing technologies in surgical practice, especially in surgical specialties like urology and gastrointestinal surgery.

This rapid advancement in medical technology poses a challenge because, training and trained surgeons need to master these new technologies to be able to practice, let alone teach their juniors. Balancing work commitments and finding adequate time to learn new skills is no easy task in today's world. In order to meet these demands, surgical education and training has to adapt, innovate and respond accordingly.

The future surgeon therefore has to be,

A. a good craftsman with an up-to-date knowledge and a sound training in contemporary technology

B. a good communicator

C. a person who can manage and work in a multidisciplinary team

D. a researcher and

E. above all, a professional with good ethics

The question is, can we produce a person who fulfils all above requirements?

My answer is yes, but the process must start during their undergraduate days in the medical school, not when they pass the selection examination to enter the Surgery postgraduate training program. First, the person should like the field of surgery and not take up the specialty for its glamour or because they have seen the surgeon as the hero saving a dying man by performing heroic surgery as portrayed in cinema.

Therefore, trainees sometimes realise too late the extent of commitments and sacrifices they have to make towards family life. This has led to some trainees finding it difficult to balance their training/work and family life.

I believe the best place to plant the seed of the future surgeon is in the Medical school, especially the Anatomy department. I have always felt that anatomy dissections were the place for a budding surgeon. Being in a dissection group teaches not only anatomy but teamwork, leadership qualities and the taste of being a surgeon, albeit on a cadaver. Teaching anatomy should be surgically oriented and I must congratulate the Department of Anatomy under our Chief Guest Professor Rohan Jayasekara for adapting early to this concept of teaching Anatomy. During our days, Anatomy was taught by pure Anatomists which was, to be honest, rather boring.

Professor Rohan Jayasekara opened the Anatomy Department to surgeons and clinicians and at present, they have clinical geneticists, general surgeons, a pathologist, a urologist, a pulmonologist, an ophthalmologist and even a radiologist in their department. Currently, they have a young recruit doing his training in plastic surgery. This is truly an academic multidisciplinary approach to learning basic sciences. This thinking outside the box has led to learning Clinical Anatomy which is both interesting and relevant from an early stage.

Other departments too have followed a similar concept. The Department of Physiology has academics consisting of physiologists, general physicians, a neurologist , a radiologist and a medical nutritionist, truly a multidisciplinary team teaching clinical physiology. This is food for thought to the current Dean who is a clinical geneticist when recruiting members in the future to all pre and paraclinical departments.

When recruiting a medical gastroenterologist as an interventional endoscopist to the Department of Surgery was mooted, there were rumblings from certain quarters. These were overcome, thanks to the foresight of the then Dean Professor Rohan Jayasekara and former Vice Chancellor Professor Kshanika Hirimburegama. Though unorthodox in the eyes of many and breaking with norms, those in our department will vouch for the wisdom of this move. This move was also supported and facilitated by Dr N Nawaratne, the Ministry of Health Gastroenterologist who worked with the University, demonstrating the benefits of a collaborative approach. The ultimate beneficiaries of this move have been the patients who get high quality care for gastrointestinal disorders and the surgical trainees in our unit who are able to witness and learn first-hand the advantages of a multidisciplinary care in patient outcomes.

I believe that medical students should be involved in the vision for the future; they need to understand how the healthcare system would look like when they start working and be prepared mentally to face the challenges of a technically advanced surgical world. It is important to provide them the exposure needed to adapt to evolving technologies early in their career. This includes using such as virtual 3D anatomy and simulation training to learn anatomy and the principles and applications of Artificial Intelligence(AI). Young, early career medical students can be groomed to achieve this. It may also be the time to explore the selection process of students to medical faculties to include criteria beyond the A'levels such as aptitude in the domains I have mentioned and other areas such as communication skills and professionalism.

Research

Demonstration of research competency is now compulsory for all postgraduate trainees in medical specialties including surgery. I believe that trainees should be given the option of taking up to 2 years of leave from the program to engage in research leading to a research degree, especially for those in academic institutions. I sincerely hope the current Director of the PGIM Professor Senaka Rajapakse will explore this option since he himself is an avid researcher and along with Professor Janaka de Silva is placed within the first 2 percent of the global researchers according to the Stanford World ranking of researchers, a feat only few other Sri Lankan doctors have achieved in the past.

The foundations for research should start from the Medical School and I commend the Community Medicine departments in our faculties for including a research project in their curriculum. This exposes the students to basic research methodology during their undergraduate career.

When I joined the University of Kelaniya in 1995, I witnessed how Professor Janaka de Silva led his team to conduct quality research.Later, working with Prof Kemal Deen who joined me in the Surgery Department at Kelaniya with a research MD from the UK, I was inspired by his critical thinking and decided to do a research degree myself. I proceeded to the UK taking two years no-pay leave to study for a Doctor of Medicine(MD) by research degree. That gave me the foundations of research methodology and helped me instill the same in my junior colleagues and encourage them to do research degrees in addition to their clinical qualifications

I am proud to state that every single demonstrator who came to me after their MBBS obtained an indexed journal publication (in PubMed or SCIE) before they started their internship. This shows how capable and bright our youngsters are and what they can achieve if given the initial guidance.

Ladies and gentlemen, I kept Professionalism and Ethics to the end because, I think this is the most important quality out of all other factors that I stated before you that a practicing surgeon should possess. Considering the recent adverse media reports about the surgical profession, I thought of adding a few thoughts of mine today. During our career, I learnt professionalism and ethics mainly from our teachers and trainers as stated in my Royal College school song which says, "we have learnt of books and learnt of men and through we will do the same". How true it is. These qualities include, commitment, dedication, compassion, honesty, integrity, empathy and communication. I wish to mention the names of those great persons from who I learnt Professionalism & Ethics. They are, Prof. RA Navaratne, Prof. AH Sheriffdeen, Dr.Tony Gabriel, Dr.Lakdasa Dissanayake, Dr.SJ Stephen, Dr.Ranjith Silva, Dr.Natkunam, Dr. MH de Zoysa and Dr.Mrs.Nandrani de Zoysa. Except during my internship, I did not work with physicians but one physician with who I did my internship in the Professorial Medical Unit I must mention, and that is late Professor David Chanmugam, a jewel of a man who I would say is a sterling example of an ideal honorable Professional in that unit who I will never forget.

Then I shall mention two other incidents that I experienced during my training career that made a permanent impact on me.

First was with Prof. R.A. Navaratne when I was a young intern with him and the Second was with Professor Nandadasa Kodagoda, an exceptionally talented teacher and a physician our faculty has ever produced.

Dear friends, all the above men have shown me what a professional should be. What I have learnt from them, I have imparted to my juniors.

Ethics also include professional fees in private practice and some colleagues have approached me and told me that the college should also address the issue. My opinion is every individual is entitled to charge what he feels he is worth, provided, professional fee is disclosed prior to surgery. Therefore, the patient can accept it or go to another. However, it is inhumane to slap a massive fee after surgery and take the patient by surprise. Please note when this happens, patients may have to sell their valuables or property to pay your fee and thereby deny their children some necessities or comforts in life. Therefore, please decide taking that money unjustly and giving your children everything on earth is fair or not and I leave the decision to you to make.

In addition, ethics include, your obligations to younger generation of medical students, doctors and surgical trainees. These include teaching commitments and training. Ask yourself whether you are punctual at work, at clinics, in the operating theatre and in your teaching commitments. Ask yourself whether you are supervising your trainees operating. Ask yourself when a trainee makes a mistake whether you help him by taking over the subsequent surgeries rather than allowing him to operate again and again unsupervised. If the answers are yes then you are a true professional with good ethics.

Also, ask yourself whether you are doing unnecessary procedures for monitory gains. Please remember there are now guidelines giving indications for surgery/ investigation for most of the surgical conditions. American, European, UK or Australasian medical association web sites give these guidelines and if you have followed those guidelines, you are safe even if a legal issue arises.

I also wish to state that, when you are the leader of the team or in a position of authority, you must always help the persons under you. Always help them to further their knowledge and to do better than you and always give preference to merit. Never try to suppress them or deny what is due to them. Be happy when they do better than you. Remember whatever good things you have done, you will be remembered for one wrong thing you have done in the past. Lord Buddha once said, “when you milk a cow you need only one drop of cow dung in the pot to spoil the entire pot of milk”.

Therefore, ladies and gentlemen, the learning points from my speech would be,

1. Surgical practice will be different in the future
Artificial intelligence(AI) and other technological advances like robotics will be in the core of surgical practice.
2. Our surgical training and practices need to change to fit the future.
3. Significant investment is required to meet the future training needs

Therefore, all our efforts should be to train a competent professional with good ethics and also to promote and help the younger generation to do better.

Finally,

I wish to thank my educated parents who were government servants who educated all their children and instilled discipline and good ethics. I also thank all my brothers and sisters some of who are present here today.

A special word of thanks to Professor Neil Mortensen who is the current President of the College of Surgeons of England who gave me an opportunity to work in Oxford as his Clinical Research Fellow from whom I learnt my colorectal surgery, GI physiology and also ABC of research. Also, Mr Christopher Speakman, Consultant Colorectal surgeon (Norfolk & Norwich University) who was my MD supervisor, Mr David Ralphs ,Consultant Surgeon (Norfolk & Norwich University)and his charming wife Diana Ralph for all the help they gave me to study for my research MD in the University of East Anglia in the UK.

I wish to thank all of you present today for attending my induction which I consider a great honour bestowed on me.

Last but not least, I wish to thank the person who is going to deliver the vote of thanks who cannot thank himself, that is Honorary Secretary Professor Sanjeewa Seneviratne who is a wonderful colleague in the department of Surgery. He was our house officer, registrar and now a colleague. A person who can be called an ideal surgeon as well as a researcher. A person who was first in the first class at every exam starting from the A’level exam up to his MD, FRCS and the PhD exams. Dear Sanjeewa, I consider it as an honour to have person of your calibre as my Honorary Secretary and may I call you to deliver the vote of thanks.

Sessions at a glimpse

Pre congress workshops
Free paper session
3 days of Academic sessions
Master classes
Meet the Experts Sessions
Trainee night
Congress banquet

Induction of the 41st President

Young surgeon with a mission

WALANT technique

Dr I H D Samitha Prasad

Consultant Plastic Surgeon

Teaching Hospital Anuradhapura

WALANT is the abbreviation for Wide Awake Local Anesthesia and No Tourniquet. This technique of local anaesthesia could replace the use of General Anesthesia and a pneumatic tourniquet in hand surgery, allowing for almost all upper limb and hand surgeries to be performed easily and more effectively. This technique was initially described and popularised by Prof. Don Lalonde, a Canadian hand surgeon, and gained more popularity in the COVID-19 pandemic era when General Anesthesia posed a greater risk of viral spread. Even now, this technique is still becoming famous as it is a very simple but effective way of anaesthetising patients for hand surgeries and as a very cost-effective and easily adaptable technique.

How WALANT can be done – The Technique:

It involves a field block using a solution of Lignocaine with adrenaline buffered with Sodium Bicarbonate for the relief of pain caused by the acidity during infiltration of the anaesthetic solution. We can use a solution of 1% Lignocaine with 1:100,000 Adrenaline mixed with 8.4% Sodium Bicarbonate 1ml for every 10mls. For larger volume infiltrations, we can dilute this down to 0.25% Lignocaine and 1:400,000 Adrenaline, retaining the same efficacy. In order to reduce the pain on the prick, it is recommended to use a 27G-30G needle and to avoid sensitive areas like the palm of the hand. Instead, a nerve block is usually practiced prior to infiltration of the solution in the surgical field more distally. Direct perpendicular penetration of the skin would definitely reduce the needle prick pain, and intensity can be blunted with pain masking with another somatic stimuli like touch or pinch on the same dermatome.

Our Experience in WALANT Technique in Hand Surgery:

We started using WALANT in the National Hospital Sri Lanka in 2020 during the COVID-19 Pandemic when most of the GA theatres were closed and restricted to life-saving procedures. In our preliminary study, we included 14 patients, of which 5 patients were routine cases, 4 secondary tendon reconstructions, and 5 acute hand trauma patients. First, the surgical dissection field was surface marked with permanent ink delineating neuro-vascular structures. We used 1.200,000 adrenaline with 0.25%-0.5% Lignocaine solution buffered with Sodium Bicarbonate. The volume depended on the surgical field involved and the patient's body weight.

Anaesthetic solution was infiltrated into tissue planes of dissection and up to 1cm away the marked borders, until the area becomes tumescent. 1st prick was done with an 26/27 G needle in the most proximal point of the surgical field or on the nerve block. Surgical incision was made when the skin is pale and anaesthetised usually after 15 to 20 mins.

The surgeon's experience during the procedure and conversion to tourniquet was observed as an indicator of troublesome bleeding. Pain during the procedure was measured with a visual analog scale. Post-operative surgical outcome was assessed in 2-week intervals in the follow-up clinic.

Results of our preliminary study – In all 12 surgeries the surgeon was satisfied with the bloodless field and none was converted to tourniquet surgery, though early frequent moping was needed at the beginning of the procedure it settled with time and was not recorded as troublesome by the operating surgeon. Maximum pain was 3/10 and average was 2.3/10. One digital artery repair was technically difficult owing to adrenalin repeatedly causing arterial spasm. Post-operative outcome was as expected with the same procedure done under GA. Since then, author has performed surgeries under WALANT on a regular basis. It is easy and convenient to find a Local theatre time slot, so it is time and resource effective to practice WALANT. In authors personal practice audits, there are more than 500 hand surgeries and the outcome was as same as in our preliminary study.

Discussion –

WALANT is a successful alternative to GA with less complications but with the same surgical outcomes. It is cost effective and eliminates the risk of GA so more suitable for high risk patients. We observed that more anxious and claustrophobic patients find this a better mode of anaesthesia than GA, simply they could listen to their favourite song playlist during the theatre procedure relieving their stress a lot.

In our series of patients, we performed forearm and hand traumatic lacerations exploration with nerve and tendon repairs, metacarpal and phalangeal fracture percutaneous fixations or ORIFs, Ligament repairs including thumb MCPJ UCL repairs with suture anchors, distal forearm and hand nerve/tendon releases, Carpal tunnel releases, Trigger finger releases and various forearm and hand level tendon transfers. In this technique as our patient is awake and had no muscle paralysis we could demonstrate the success of our tendon or ligament repairs then and there on the operating table by asking the patient to move his hand or fingers. We could without much difficulty set the tension of tendon transfers and could test the results on the table convincing the patient as well so helping him to achieve neuroplasticity on subsequent hand therapies to achieve the best outcome of our procedure.

Some patients complained of mild to moderate aching pain while handling tendons which probably originated from the tendon stretch receptors located higher up away from the surgical field on the pull of the distal end. We could easily reduce the severity of this by gentle handling and warning the patient about the upcoming pain, so it was not a surprise for them.

There are now many publications coming up after the initial introduction of this technique by Pro D Lalonde proving the effectiveness of the procedure with a very good outcome. Literature has not yet revealed any significant adverse outcomes and has not seen any digital necrosis with the lignocaine or bupivacaine but with procaine with adrenaline.

Is this applicable to the Sri Lankan set up -

Definitely yes, we are probably still recovering from the worst ever financial crisis in the Sri Lankan history and this technique certainly will reduces the cost on the health sector. General anesthesia theatre time is precious and can be reserved for other patients in need like pediatric patients.

On a personal note, I am now introducing this technique to the Teaching Hospital Anuradhapura these days with very good responses from patients as well as the staff. Patient turnover is also very efficient as the WALANT infiltration can be done outside the theatre so saving theatre room time. We are planning on opening a separate day surgery unit with WALANT to reduce the load on the other theatres as well.

As Plastic and Reconstructive Surgeons covering surgeries on hands, we always would like to train our colleges on this novel technique so everyone can experience the best of this technique in the future.

References :-

1. Tan E, Bamberger HB, Saucedo J. Incorporating Office-Based Surgery Into Your Practice With WALANT. J Hand Surg Am. 2020 Oct;45(10):977-981.
2. Hobday D, Welman T, O'Neill N, Pahal GS. A protocol for wide awake local anaesthetic no tourniquet (WALANT) hand surgery in the context of the coronavirus disease 2019 (COVID-19) pandemic. Surgeon. 2020 Dec;18(6):e67-e71.
3. Lalonde DH, Wong A. Dosage of local anesthesia in wide awake hand surgery. J Hand Surg Am. 2013 Oct;38(10):2025-8.
4. Maliha SG, Cohen O, Jacoby A, Sharma S. A Cost and Efficiency Analysis of the WALANT Technique for the Management of Trigger Finger in a Procedure Room of a Major City Hospital. Plast Reconstr Surg Glob Open. 2019 Nov;7(11):e2509
5. Far-Riera AM, Pérez-Uribarri C, Sánchez Jiménez M, Esteras Serrano MJ, Rapariz González JM, Ruiz Hernández IM. Prospective study on the application of a WALANT circuit for surgery of tunnel carpal syndrome and trigger finger. Rev Esp Cir Ortop Traumatol (Engl Ed). 2019 Nov-Dec;63(6):400-407.
6. Lalonde DH. Latest Advances in Wide Awake Hand Surgery. Hand Clin. 2019 Feb;35(1):1-6.
7. Pires Neto PJ, Ribak S, Sardenberg T. Wide Awake Hand Surgery Under Local Anesthesia No Tourniquet in South America. Hand Clin. 2019 Feb;35(1):51-58.
8. Rhee PC, Fischer MM, Rhee LS, McMillan H, Johnson AE. Cost Savings and Patient Experiences of a Clinic-Based, Wide-Awake Hand Surgery Program at a Military Medical Center: A Critical Analysis of the First 100 Procedures. J Hand Surg Am. 2017 Mar;42(3):e139-e147.
9. Ki Lee S, Gul Kim S, Sik Choy W. A randomized controlled trial of minor hand surgeries comparing wide awake local anesthesia no tourniquet and local anesthesia with tourniquet. Orthop Traumatol Surg Res. 2020 Dec;106(8):1645-1651.

College activities on digital media

SETS
Surgical Education
& Training Sessions

Date: Saturday 01st April 2023

Time: from 8.00 am

Venue: Auditorium
The College of Surgeons of Sri Lanka
6, Independence Avenue
Colombo 7

Live transmission to
Teaching Hospital Kandy
Teaching Hospital Peradeniya
Teaching Hospital Jaffna
Teaching Hospital Karapitiya &
Teaching Hospital Batticaloa

Case based discussion in Upper GI Surgery

08.00 - 08.30 Achalasia and motility disorders - Dr Rasika Bulathsinghala

08.30 - 09.00 Upper GI polyps - Dr Rukman Sanjeewa

09.00 - 09.30 Carcinoma of the stomach - Dr Amal Priyantha

09.30 - 10.00 Carcinoma of the esophagus - Dr Rasitha Manathunga

10.00 - 10.20 Functional dyspepsia : Dr Chathuranga Keppetiyagama

NTMC

ATLS

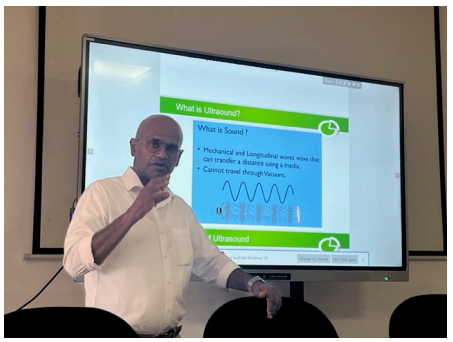
HOLT

DMMT


Birth of a New Program ...
Definitive Surgical Trauma Care (DSTC)


Birth of a New Program ...
Definitive Surgical Trauma Care (DSTC)

ESTC


What is Ultrasound?
What is Sound ?
Mechanical and Longitudinal waves wave that can transfer a distance using a media.
Cannot travel through Vacuum.

SHO training program Jaffna

Pre Intern Program '23

Organized by Ministry of Health

In collaboration with

The College of Surgeons of Sri Lanka

17th May 2023		
08.30 am - 08.45 am	Welcome address	Prof D N Samarasekara - President CSSL
08.45 am –09.00 am	Introduction and foundation of a diagnosis	Dr Gayan Ekanayake
09.00 am - 09.30 am	Analysis of pain back to basics	Prof Sanjeewa Seneviratne
	Abdominal pain symposium	
9.30 am to 10.00	Surgical abdomen	Prof S Sivaganesh
10.00 am - 10.30 am	Peritonitis	Dr Randima Nanayakkara
10.30 am - 11.00 am	Appendicitis	Dr Duminda Ariyaratne
11.00 am - 11.30 am	Epigastric Pain	Dr Malith Nandasena
11.30 am - 11.50 am	Intestinal obstruction	Dr Nissanka Jayawardhana
11.50 am - 12.10 pm	Pre op evaluation preparation of patients for routine surgery	Prof Sanjeewa Seneviratne
12.10 pm - 12.30 pm	Endoscopy preparation	Prof Dakshitha Wickramasinghe
	Trauma Introduction	
12.30 pm - 13.00 pm	Abdominal trauma	Dr Kirthi Abayajeewa
13.00 pm - 13.20 pm	Lower limb fractures	Dr Narendra Pinto
13.20 pm - 13.40 pm	Assessing injured hand	Dr Kolitha Karunadasa
13.40 pm - 14.00 pm	Renal injuries	Dr Ranga Wickramarachchi
14.00 pm - 14.30 pm	Chest injury	Dr Sumana Handagala
18th May 2023		
08.00 am - 08.30 am	Consent and professionalism	Dr Jayaindra Fernando
08.30 am - 09.00 am	Wounds and dressings	Dr Gayan Ekanayake
09.00 am - 09.30 am	Diabetic foot disease	Dr Nalaka Gunawansa
09.30 am - 10.00 am	Debridement and Skin cover for acute wounds	Dr Kavinda Rajapaksa
10.30 am - 11.00 am	Skin cover for chronic wounds - ward preparations for better outcome	Dr Oshan Basnayake
11.00 am - 11.20 am	Vascular injuries	Dr Thushan Gooneratne
11.20 am - 11.40 am	Head injury	Dr Nirukshan Jayaweera
11.40 am - 12.00 pm	Burns	Dr Gayan Ekanayake
12.00 pm - 12.20 pm	Ureteric colic	Dr Nishantha Liyanapathirana
12.20 pm - 12.40 pm	Urinary retention and haematuria	Prof Ajith Malalasekera
12.40 pm - 13.00 pm	Writing a diagnosis card Post op ward round	Prof Sanjeewa Seneviratne
13.00 pm - 13.20 pm	Auditing your progress	Prof Dakshitha Wickremasinghe
13.20 pm - 13.40 pm	Patient transfer	Dr Mihira Bandara
13.40 pm - 14.00 pm	Work life balance	Prof Aloka Pathirana

Will be Conducted via Zoom

Scan the Qr Code to

Dr Gayan Ekanayake
Course Coordinator

Professor Sanjeewa Seneviratne
Honorary Secretary
The College of Surgeons of Sri Lanka

OTST


OTST
Online Teaching for Surgical Trainees
Basic Lecture Series - 02
The College of Surgeons of Sri Lanka
Fundamentals of Antibiotic Usage in Surgery
(Rational Antibiotic Therapy & Chronic wounds and concept of wound infection continuum)
By
Dr Mahen Kothalawala
Consultant Microbiologist
National Hospital, Colombo
16th March 2023
02:00 pm – 04:00 pm
Organizer – Dr Gayan Ekanayake
gayanse2003@yahoo.com
Scan the QR code to register for the lecture series
Professor Sanjeewa Seneviratne
Honorary Secretary

It is my honour and privilege to serve as the 41st President of the College of Surgeons of Sri Lanka having been part of this College for 21 years as a member, Assistant Treasurer, Secretary, Vice President and President-Elect.

Thanks to the generosity of Dr Noel and Mrs Nora Bartholomeusz, the College has moved from a small room at Wijerama House to the present magnificent building that combines both the vintage and the modern. In the year 2000, Prof A H Sheriffdeen (President of the College) along with Mrs Anne Ranasinghe and late Dr Vimala Navaratnam were instrumental in facilitating this process and I was fortunate as the secretary that year to be one of the signatories to this transfer with Professor A H Sheriffdeen.

As an academic and a postgraduate trainer, the theme “Training the Future Surgeon” is close to my heart. The rapid evolution of medical technology poses both opportunities and challenges to surgeons and trainees. The College needs to prepare its membership to this reality and foster ties with our regional and international partners including the SAARC Surgical Care Society, professional colleges in South Asia, Australasia and the Royal Colleges of Surgeons of the UK towards this objective.

The seeds of a surgical career are often laid down in the company of inspirational surgeons. I call our membership to be role models to motivate medical students and young doctors to be participants of this vision for the future.