

Use of laparoscopic instruments challenged



I would like to congratulate Dr. John George on his very thorough article, "Laparoscopic evaluation of the pelvis: refocusing on the basics" [September].

I do, however, have 2 concerns. First, Dr. George states that the surgeon should "insert a...0° laparoscope into the channel of a 10-12 transparent, bladeless trocar." I do not know of any data suggesting that a 10-12 transparent bladeless trocar is any safer or easier to use than a simple reusable metal trocar. If Dr. George's recommendation is based on any scientific data, I would enjoy seeing that information.

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Second, Dr. George suggests the surgeon "consider using ultrasonic shears to minimize thermal injury to the bowel." Again, I am not aware of any study published in a peer-reviewed journal that reaches this conclusion and would appreciate any data that supports his claim. Although I have no argument with another surgeon choosing to use this technology, I personally have found it to be slow and relatively useless in many of the 8,000 laparo-

scopic procedures I have performed in the last 20 years.

If the use of transparent bladeless trocars and ultrasonic shears are simply Dr. George's preference, it should be stated. Otherwise, it appears as though Dr. George could be promoting certain products or companies.

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Dr. George responds:

While I have never met Dr. Johns, I am familiar with some of his publications relevant to Gyn endoscopy. He is obviously a well-accomplished endoscopist, having performed more than 8,000 procedures. I respect his opinion, and am flattered that he has made positive comments about my article. His suggestion, however, that 2 of my statements are commercially motivated have no basis in fact.

In all phases of laparoscopy, I strive for patient safety. It is well recognized that the blind phase of laparoscopy—abdominal entry—is the most hazardous.¹ Complications have been described with open as well as closed techniques, and with all varieties of trocar systems, including shielded trocars and those with optical enhancement.^{2,3} Until scientific data indicates superiority of any method, I will continue to recommend the promotion of patient safety by selecting patients wisely, using safety precautions in high-risk patients, minimizing the blind phase, and using preferred techniques of trocar insertion as mentioned in the article.

I adopt a similar philosophy in the use of energy sources. Whenever possible, I lyse adhesions mechanically using scissors. When an energy source is indicated, the risk of thermal injury is assessed. For the physician

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skilled in electrosurgery, that modality is relatively safe and cost-effective. Thermal injury may be difficult to predict, regardless of the surgical expertise of the operator and his knowledge of the physics of electrosurgery. The hazards of monopolar electrosurgery are many. Electron density, the flow path of electrons, capacitance coupling, and lateral thermal spread are features which, if not well understood, pose risk of patient injury out of the operative view field. The ultrasonic shears is an alternative with less inherent risk of thermal injury.

Undoubtedly, gynecologic endoscopy has made dramatic progress in the past 25 years. During this time, it has survived the criticisms

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of those who would claim “no scientific data,” as proven techniques of minimally invasive surgery began to supplant traditional methods with resulting patient benefits. We must shape our practice on a solid scientific foundation. However, when data is not yet available we should use current knowledge, along with a common-sense approach to provide safe, quality care to our patients. ■

REFERENCES

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formance, they run the serious risk of “diluting” medical education. By that I mean residents working 80 hours a week are unlikely to achieve the same case volume as those who put in 100 or more hours over a 4- to 5-year residency. In fact, in many countries where resident work hours have been restricted, the training interval has been extended, especially for surgical disciplines. Still, many authorities believe little additional learning takes place after 80 hours of work per week.

Implications for attendings

What about attending physicians? If acute and chronic sleep deprivation is demonstrated to negatively impact physician performance (which is probably the case), will attending physicians be required to reorganize their call schedules to avoid working continuously for more than 24 hours? Many attending physicians covering obstetrics do “power weekends,” working continuously from Friday night through Monday morning or evening. If few patients are in labor, then the call is “light.” But if many patients are in labor—or if 1 patient gets very sick—the power weekend is likely to cause severe fatigue in the attending. What expectations should patients have about the alertness and restedness of their attending physicians?

The ACGME resolve to change resident duty hours is likely to spur a reexamination of the practices of attending physicians as well, particularly in specialties where continuous duty for more than 24 hours is routine. Like the resident’s extended work week, the attending’s 60- to 84-hour continuous call schedule may become a routine of the past. ■



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