LETTERS

Optical-access trocars: Good idea or higher risk?

I read with interest the 2 recent articles on laparoscopic surgery: "Avoiding vascular injury at laparoscopy," by Michael Baggish, MD (October 2004), and "Laparoscopic surgery in the obese: Safe techniques," by James K. Robinson III, MD, and Keith B. Isaacson, MD (March 2005).

Although complications from the use of optical-access trocars have been briefly described, I believe primary trocar insertion under direct visualization (video) is safer than "blind" or "open" techniques. Using an optical-access primary trocar, an experienced laparoscopist can clearly identify the subcutaneous tissue, fascia, and peritoneum, allowing for a more controlled and "thrustless" insertion into the peritoneal cavity. Even when extensive intraperitoneal adhesions are present, peritoneal windows can be identified by direct visualization.

Of course, the ability to recognize tissues traversed by the laparoscope is key to minimizing primary trocar injuries. "Seeing where you are going" may not prevent injuries if the physician cannot interpret what he or she is seeing. Fortunately, the technique can be mastered with little training. I have been using it for 15 years without any primary trocar-related injuries.

Moshe R. Peress, MD
Boca Raton, Fla

"There have been numerous reports of injury utilizing these 'safer' optical trocars"

Dr. Baggish responds:

Contrary to Dr. Peress' assertion, these devices are not safer than blind or open techniques, as the various layers are poorly defined.[1]

In 2002, Sharp et al reported 37 major vascular injuries with these devices involving the aorta, vena cava, and iliac vessels.[2]

In addition, 18 bowel perforations, 3 liver lacerations, and a stomach perforation were cited. Four of the patients died as a result of these complications.

The optical-access trocar has not proved to be a safer device.

REFERENCES

1. Narendren M, Baggish MS. Mean distance between primary trocar insertion site and major retroperitoneal vessels during routine laparoscopy. J Gynecol Surg. 2002;18:121–127.
2. Sharp HT, Dodson MK, Draper ML, et al. Complications associated with optical access laparoscopic trocars. Obstet Gynecol. 2002;99:553–555.

Drs. Robinson and Isaacson respond:

Our review of peritoneal access in obese patients did not specifically mention the use of optical-access trocars. However, our approach to primary intraperitoneal access for all our patients, obese or not, does involve an optical trocar. While our experience and intuition support Dr. Peress' assessment that optical trocars are less dangerous than nonoptical ones, there have been numerous reports of injury utilizing these "safer" trocars,[1-3] and we are unaware of any good comparative data that support our bias.

REFERENCES

1. Thomas MA, Rha KH, Ong AM, et al. Optical access trocar injuries in urological laparoscopic surgery. J Urol. 2003;170:61–63.
2. Schafer M, Lauper M, Krahenbuhl L. Trocar and Veress needle injuries during laparoscopy. Surg Endosc. 2001;15:275–280.
3. String A, Berber E, Foroutani A, Macho JR, Pearl JM, Siperstein AE. Use of the optical access trocar for safe and rapid entry in various laparoscopic procedures. Surg Endosc. 2001;15:570–573.

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Should an expert comment on his study?

I was shocked to see that the expert commentary on the study of herpes type 2 serologic testing ("Examining the Evidence," April 2005) was written by one of the original article's authors, Zane A. Brown, MD! How can one possibly consider the commentary serious evaluation?

Deborah Cohan, MD, MPH
Assistant Clinical Professor
University of California, San Francisco

Dr. Barbieri responds:
We are glad Dr. Cohan read "Examining the Evidence" and took the time to point out her concerns. Dr. Brown was invited to comment because he is among the foremost researchers and clinicians in the field of human herpes infections, and we thought he would provide valuable insight into the study's findings. In many cases, a study's authors are the best people to ask about its strengths, weaknesses, and potential clinical implications.

Just as medical schools and hospitals are happy to have chief investigators give Grand Rounds or continuing education lectures about their experience when important findings are published, a printed form of the same sort of commentary, we thought, would be similarly informative.

That said, we did neglect to include the disclosure that was published with the original study, stating that GlaxoSmithKline provided support for the study, and we apologize for that omission.

Let "3-strikes rule" cover lawyers, too

I enjoyed Dr. Robert L. Barbieri's February 2005 editorial, "3 strikes and you're out of a job." As I'm sure he is aware, "losing" a liability settlement often has very little to do with competence and a lot to do with ignorant juries, false testimony from prostituted physicians, and often unavoidable events such as cerebral palsy in an extremely premature infant or brachial plexus injuries.

However, I would happily endorse a "3 losses and you're out" rule if the attorneys would adopt the same. If they lose 3 cases, it must be due to negligence or incompetence, or both. Should they not live by the same rules as we?

Kevin Davis, MD
McAllen, Tex

Dr. Barbieri responds:
I appreciate Dr. Davis' outstanding suggestion, which is beautifully symmetric in its logic.

1% filing fee would fix liability crisis

No frivolous lawsuits. No outrageous awards. No tort reform necessary.

Too good to be true? Maybe not.

I propose a federal filing fee of 1% of the award being sought, to be paid by the lawyers bringing the suit. Doctors, hospitals, the medical delivery system in general, insurance companies, and the US government would benefit.

If Congress had fewer lawyers, it might be possible.

John C. Chisolm, MD
Southaven, Miss

Dr. Barbieri responds:
Dr. Chisolm's plan is creative, but I think it unlikely any legislative body will pass it.

Care to comment on an article in this issue?

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"'Losing' a liability case often has little to do with competence and a lot to do with ignorant juries, false testimony from prostituted physicians, and unavoidable events"