Laparoscopic Colectomy: Tricks, Tips, & Pearls

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We rarely find that people have good sense unless they agree with us.
-Francois, Duc de la Rochefoucauld, 1678

Laparoscopic Colectomy

Still < 1/3rd of colectomies performed in the U.S.

Three Stages of New Knowledge

1. Declared impossible
2. Denounced as dangerous and therefore capable of being done in MY hands only (usually requiring a prospective randomized study which just happens to available at MY institution)
3. Accepted as self-evident

Laparoscopic Colectomy: Myths

- It should only be done by colorectal (or laparoscopic) surgeons
- The learning curve is too long
  - It’s too hard for mere mortals
- It shouldn’t be done for cancer
  - A surgeon should learn on pts w benign disease

Myth # 1

It should only be done by colorectal (or laparoscopic) surgeons
Myth # 2

The learning curve is too long
“It’s too hard for mere mortals”

The Learning Curve: Definition

- A curve plotting performance against practice
- A course of progress while learning something or performing some task

The Learning Curve in Laparoscopic Colectomy:

- Length of learning curve
  - HIGHLY variable; ranges from 15 – 60 cases
  - Dependent on level of colorectal experience in ASCRS registry
  - Dependent on laparoscopic experience in smaller series published by acknowledged 'laparoscopic surgeons'
  - No breakdown by case type or diagnosis

‘Traditional’ Training for LAC

- 1 – 3 day didactic and laboratory course specifically aimed at LAC skills
- 1 – 3 ‘proctored’ cases; proctor rarely affiliated with surgeon
- Random assignment of assistant with any person as camera operator
- Often little or no examination of results

Laparoscopic Training @ KFH-SD

- Two surgeons identified as ‘vanguards’
  - Specific interest in laparoscopic surgery
  - Attendance at ‘hands-on’ course in advanced laparoscopy
  - 1-3 proctored cases
  - Development of an advanced laparoscopic ‘team’
  - Essentially exclusive working arrangement

The Learning Curve @ KFH-SD

- Do we have one?
  - Is it similar to others?
  - If not, why not?
Study Method

- Retrospective review of all patients who underwent attempted LAC 1992-1997
  - Inpatient and outpatient chart review
  - Data collected included demographics, BMI, operation performed, op time EBL, time to p.o. intake, LOS, conversions, complications, surgeon, assistant, diagnosis (if cancer, stage, F/U period, recurrence rate and location)
Influence of Proctor as Assistant: Closed Cases

Laparoscopic Colectomy Tip #1

Get Good Help

Laparoscopic Colectomy Tip #2

See all that you can see

Laparoscopic Colectomy Tip #3

If you do what you did, you’ll get what you got!

Laparoscopic Colectomy Tip #4

Find some things you like and stick with ‘em!

But I can’t possibly do things the same way!
Laparoscopic Colectomy Pearl #1

An uneasy body begets an uneasy mind

The Laparoscopic Asana

An Ergonomically “Correct” Posture

Laparoscopic Colectomy Pearl #2

Port placement is 90% of the case

Proper Port Placement

- The ‘Amphitheater’ Arrangement
  - Ideal working arrangement has the ‘target’ organ located ‘center-stage’ with instruments arrayed around the target in increasing concentric semicircles
  - The camera should be in the middle of the last row to facilitate visualization of all instruments

Failing to plan is planning to fail

-Winston Churchill
Laparoscopic Colectomy Pearl #3
Operative Planning

• “Storyboarding”: The “pre-enactment” of necessary operative steps with an outline of the equipment required and the routes of access to expose, view, and manipulate the ‘target’. This requires consideration of port & equipment placement, required ‘actors’, and patient positioning.

Myth #3
Laparoscopic colectomy shouldn’t be done for cancer
Surgeons should learn on pts with benign disease.

Random Musings
• Modified lithotomy for anything left of the middle colic

Random Musings
• Modified lithotomy for anything left of the middle colic
• Gravity is the BEST (and safest) retractor
• It’s called laparoscopically-assisted for a reason
  • Do as much CLOSED as possible
• Use a wound retractor/protector
• Avoid the ‘black hole’