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Original Article

Hysterectomy: The Knife In The Dark

Case Report

Angiokeratoma Circumscriptum In Pediatric Patient - A Rare Zosteriformpattern

Giant Myxoid Liposarcoma Of Thigh - A Clinical Challenge

Methods & Devices

Video Inguinal Block Dissection : A Minimally Invasive Procedure With Less Morbidity

Editor :

Dr Dilip Gupta

For Circulaion to Members only

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EDITORIAL

Dear Friends

Prof. N. Rangabashyam, (79) ; a renowned gastroenterologist, died peacefully in his sleep on 14th July 2013, in his home at Chennai. He was a well known specialist of Gastroenterology and proctology. He had many 'firsts' to his credit : ostomy department, enterostomal therapy department for nurses, staplers in surgery in India, laparotstomies etc. Indeed it was a great loss to our fraternity.

We have many members who are in medical colleges, corporate hospitals and many other places, getting cases worth publishing. What is required is a little extra effort and jotting down on paper. I am still waiting for the contributions from our members.

Dr Dilip Gupta
Editor

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ORIGINAL ARTICLE

Hysterectomy: the Knife in the Dark

S.K.Basu

Hysterectomy is the second most common major surgical procedure performed in women worldwide. In USA alone, approximately 600,000 operations are carried out annually, and almost one-third of women have had a hysterectomy by the age of 60 years. Data suggests 75 percent of those hysterectomies performed annually in the United States for various conditions may be unnecessary. In the UK, the corresponding figure is one in five women. In a single year, 71,000 women in Canada will have a hysterectomy, the majority as a first-line treatment for conditions that are not life threatening. Compared to a higher frequency of hysterectomy (HT; 10-20%) in other countries a lower rate (4-6%) has been reported from India. Considerably lower level of medicalization of menopause among women, their lower status in society, poverty, illiteracy, 'culture of silence', fear of operation and higher threshold of their tolerance, has been cited as the cause of lower incidence of Hysterectomy in India. But, going by the recent report, this claim does not look realistic.

The reality is that increasing number of young women in India are undergoing surgeries to remove uterus and ovaries. It has raised eyebrows of many quarters including senior gynecologists and senior members of the Federation of Obstetrics and Gynecology Society of India. The Health minister of Chhattisgarh state, in an interview said "Women were deliberately ill-advised by doctors, who removed their uterus to get money." He claimed, "As per my information doctors have so far managed to make roughly 2 crores (10 million rupees) in recent months by removing uterus without any valid medical reason". Deborah Cruz, an Experienced Founder Editor and Chief Creative Officer @ The TRUTH about Motherhood wrote "India's unneeded hysterectomies violate women's rights. Why are they performing unneeded hysterectomies like they are going out of style, shirking their Hippocratic Oath and removing the very essence of what makes most of us feel like women? Is it for money?" Recent audit by an insurance company confirmed this observation and raised a similar voice. It showed that more than 500 women under the age group of 25-35, at least 100 of them in the 25-30 age groups had undergone hysterectomies. More surprising is the fact that in a majority of the case sheets, doctors have mentioned small fibroids, non-cancerous conditions, causing excessive bleeding as the reason for removal of the uterus or ovaries.

Why is this happening? It remains a burning question that need to be answered. Several issues need to be scrutinized to find out the motives of this overkill.

Surgeon's expediency: Why?

From a surgeon's viewpoint, the hysterectomy may be a simpler, cheaper procedure than any of the present options. He may be comfortable in performing a particular technique but reluctant to learn a newer, less harmful procedure that could minimize the impact of the surgery on patients. It is a fact that some common symptoms, for which women seek medical help and are routinely advised hysterectomy, can be treated by other

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conservative and non-conventional means. Interestingly these alternatives are within the frame of modern medicine. Women and their families often go to a medical practitioner with a pre-conceived conviction about hysterectomies. Unfortunately the reiteration of the surgeon with or without prior diagnostic tests convinces these ignorant women further regarding the need for surgery. Data collected and analysed by Dr S.V. Kameswari and Dr Prakash Vinjamuri from Andhra Pradesh shows that women were being actively pushed towards unneeded hysterectomies especially by private medical practitioners. Re-imbursement from insurance companies encouraged them the faster, less skillful approach. The costs incurred by poor families in these unindicted hysterectomies became an easy mean to earn quick buck for the private practitioner.

The data further suggests that ethical considerations which require alternative treatment options, clear consultations with the patients, obtaining informed consent, taking up follow up procedures etc., were clearly missing in the case of these young women who got hysterectomised. The surgeons and other healthcare providers were not interested in briefing the patients or the family members about the consequences of the surgery or look at alternatives. It reflects the careless attitude of the healthcare providers. It is also apparent that the patients were not told about the exact nature of treatment for instance, that ovaries were also being removed. Analysis also reveals that no follow up procedures were adopted. Patients were left in the dark, nevertheless pointless hysterectomy went on.

Deliberate down play and lack of outcome studies

It is known that Hysterectomy alters the biological and sexual clock of the women with long term adverse consequences. Side effects include hot flashes, depression, anxiety, osteoporosis, generalized fatigue, greater risk of heart disease, stress and urge incontinence, masculinization, insomnia, bowel dysfunction, mood swings, just to mention a few. Sadly and traditionally health care providers have downplayed the risks involved with the operation itself and its many lasting consequences. Going for hysterectomy is a serious decision, more so, because it involves the alteration of a woman's sexual anatomy and has such long-term effects on a woman's health. It should be an informed one and discussed at great length with the patient so that they understand all possible consequences. As mentioned earlier, medical ethics is ignored. So where is the gap? Is it knowledge or the way they practice! Considering the fact that hysterectomy remained one of the most common gynecological surgeries for several decades, it is hard to belief that gynecologists remained unaware of side effects. Therefore the serious gap that exists is largely due to the way they practice and that is a matter of violation of the rights of the patient and disregard for medical ethics!

Surprisingly, even in western world there was very little follow up care for hysterectomised women. It is only within the past few years that researchers have begun to systematically assess its outcomes and recently provided valuable new information on the short-and medium-term health outcomes of hysterectomy. In addition, epidemiologic studies of its long-term consequences have matured, allowing better estimation of outcomes. Till then all ethical issues and risks related to hysterectomy will be buried, needless hysterectomy will be animated to tell the tale.

Government schemes, privatization and no regulation to health care

Have government sponsored health schemes made it easier for hospitals and

doctors to offer the option of surgery more widely than before? The phenomenon of an increased utilization of health services covered by State health insurance schemes in India is not new. Studies have shown this happening with schemes such as Yeshasvini in Karnataka, Arogyashree in Andhra Pradesh, and Kalaignar in Tamil Nadu. Patients are ready to accept hysterectomy mainly because they do not have to pay at the point of care even if the surgical procedure may be an unnecessary intervention. Many health care providers in private set up take the full advantage of this and indulge in excessive interventions since they get paid for each intervention. Medical circle is totally aware of this fact. Regrettably no regulation of the indications, processes and the outcomes of health care make it free for all. As a result deliberate poorly functioning public health system makes way for a profit oriented private medical system. Unnecessary hysterectomy goes on unrestrained!

Women's Sexual Health: **What it is!!? Not considered as an issue!**

The eyes only see what the mind is prepared to comprehend. Women's sexual health was never taught during my post graduate training course and it is unlikely that the same is being taught now. Therefore for obvious reason the issue of post hysterectomy sexual dysfunctions, namely diminished orgasmic response, painful intercourse and loss of libido draws hardly any attention of gynecologists and not discussed with the patient prior to surgery. Removal of uterus and its appendages causes damage of nerves and shortening of vagina. These two factors may cause diminished orgasmic response and painful intercourse respectively. Even the ACOG admits to vaginal shortening at hysterectomy in its 1999 pamphlet “Understanding Hysterectomy”. It states clearly that if the hysterectomy procedure requires vaginal shortening, deep thrusting with intercourse may become painful. Loss of libido is another form of sexual dysfunction, which is the direct result of oophorectomy (removal of the ovaries).This problem is getting lots of attention lately but the services are focused only at women who still have their reproductive organs, and not the oophorectomized women. If the vulnerable women can sacrifice their uterus, once was considered as an essence of womanhood in India, they can put out of their mind the problem of diminished orgasmic response, painful intercourse and loss of libido and never come out openly. More mechanical and less humane approach of useless hysterectomy gets sanction and legitimized.

Women's helplessness and misleading act

Going by the report, there is an induced demand for hysterectomies, with women asking for the procedure as if it is the only universal remedy. Some women who had recently undergone hysterectomy even recommend the procedure to others as a permanent solution to their agony and paint a rosy picture of post hysterectomy life. They don't recognize the problem because after effects of hysterectomy tend to surface over time, sometimes years after the operation. Quite often they themselves do not associate their symptoms with the surgery and neglect to take treatment for the adverse side effects. A study by Joshi (1998) revealed that some women viewed hysterectomy as a long-term solution to the 'pain' and 'dependency' during the days of monthly menstruation. They want others to know that their story is a “positive” one. Older women feel uncomfortable talking about their surgery and the difficulties they faced because of it over the years. The report shows that the hysterectomy rate is highest in poor, rural regions where the level of education is also low. All these analysis indicate that women are vulnerable, scared, uninformed of options or

ignorant of the actual consequences. Hysterectomies flourish at the expense of vulnerability, panic and ignorance of poor women.

Awareness, education and initiative: Key to Change

Women continue to subject themselves to unnecessary hysterectomy even when alternatives do exist. Now we know the reason. But is there a way to stop it? Can the poor, misinformed women be saved from the clutches of unscrupulous practitioners who make their living by performing needless hysterectomy? The answer is perhaps "Yes". However it needs efforts which are worth making. The absolute numbers of women afflicted by late sequel of hysterectomy may be relatively low, but the impact of these late complications is often life changing. Considering huge number of hysterectomies that are performed every year world wide, its long term effect on women's health may be enormous. Therefore time has come when women should take charge of their own health; seek out information on hysterectomy. To make it happen they need to be educated which community health education program can provide. Let them discuss with their physician, but ultimately make their own informed decision. Voluntary organizations and organizations dealing with public health should take the initiative in educating women.

It is also high time for Govt. to act and realize that their health insurance scheme is not working in a manner that it should be and is only increasing unhealthy health seeking behavior more by poor women from rural areas where the level of education is low. In fact many critics of unnecessary hysterectomies feel that government schemes are responsible for increasing role of the unregulated private sector that is leading to high hysterectomy rates. Therefore Govt. has to act urgently to optimize the quality of care, regulate the indications and improve the outcome of health care by gathering data on the costs and complications for each provider, and investigate where these are excessive.

Teaching institutions need to change their curriculum for teaching post graduate students of Gynaecology. More emphasis is needed to teach other methods that are less harmful to tackle the problems for which hysterectomy is commonly advocated. At the same time various issues related to women's sexual health need to be discussed thoroughly to have a better understanding of sexual health.

Hysterectomy today is labeled probably as the best example of a needless surgery whose consequences may prove to be devastating, often with life-long physical, emotional and sexual consequences. No drugs or other treatments can replace ovarian or uterine hormones or functions. The loss is permanent. Women deserve better and humane approach. To prevent this loss, proper counseling and educating women about their anatomy, the alternatives methods available and consequences of hysterectomy is urgently needed and this is possible only with the persistence help from all quarters including Govt. organization, social and community health workers and healthcare providers.

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CASE REPORT

Angiokeratoma Circumscriptum In Pediatric Patient - A Rare Zosteriformpattern

Jain S, Bisne E*, Mehra BK^, Shivkumar VB[#], Gupta D^, Gangane N[#]*

Abstract

Angiokeartomas are asymptomatic hyperkeratotic vascular skin lesions showing histological combination of superficial dermal vascular ectasia and hyperkeratotis. Angiokeratoma circumscriptum is a vascular malformation of the vessel of papillary dermis. On histopathlogy the epidermis shows variable degree of acanthosis,paplilomatosis and compact hyperkeartosis with elongation of rete ridges. We hereby report a case of angiokeratoma circumscriptum in a zosteriform pattern of a young female child treated successfully by surgery.

***Key Words :** Angiokeratoma cicumscriptum, zosteriform, female, foot, sugical excision.*

Introduction :

Angiokeratomas are hyperkeratotic vascular cutaneous lesions which may be localised or diffuse.The localized forms are angiokeratoma circumscriptum, angiokeratoma of Mibelli, solitary angiokeratomas and angiokeratoma of Fordyce (invoiving scrotum or vulva)[1] and the diffuse form is angiokeratoma corporis diffusum associated with metabolic disorder (Fabry's disease). Angiokeratomas are group of telegiectasias with prominent epidermal response in the form of hyperkeratosis[2]. The lesion is rare and onlyfew cases have been reportedin literature. It is clinically important because of its morphologic similarities to malignant skin tumors . Therefore, theserare skin lesions must be recognized by physician and surgeons who manage skin tumors[3] .

Case Report :

An 8 years old female child got admitted with complaints of a progressive large verrucous reddish black coloured growth over dorsum of right foot since birth. There was history of on and off trauma and bleeding from the lesions. There was no history of lesions anywhere else in the body. On examination the growth was progressive in nature, 5 cm x 4 cm, irregular, verrucous,firm to hard in consistency,mobile and tender on palpation presenton the dorsal aspect of her right foot extending to the medial half of the right sole (zosteriform). She had hyperpigmentation in the surrounding area. Her physical growth and mental development were normal. Adjacent joint movements were normal, limb length discrepancywas absent and there was no neurological deficit. Other systemic examination were within normal limits. Routine

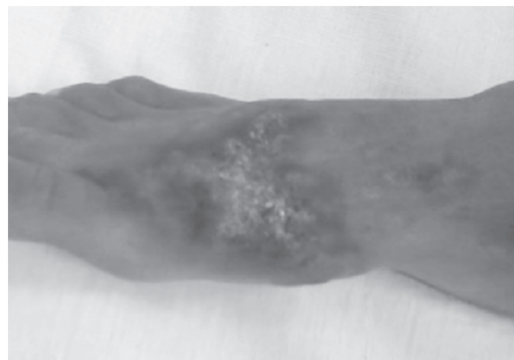

***FIG. 1 -** Verrucous lesion on the dorsum of right foot with surrounding hyperpigmentation.*

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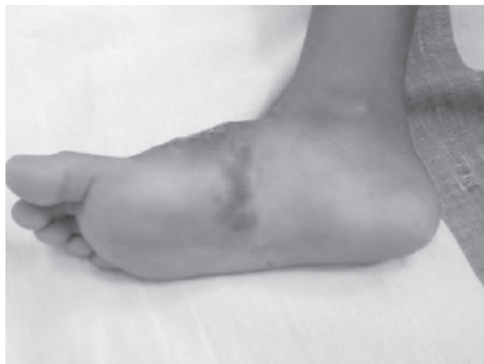

FIG. 2 - Lesion extending upto the sole of the right foot.

laboratory investigations were normal. Biopsy was done for histopathological examination. The histology findings showed numerous, dilated, thin-walled, congested capillaries mainly in papillary dermis underlying an epidermis that showed variable degrees of acanthosis with elongation of rete ridges and hyperkeratosis (Fig. 3). On basis of clinical examination and histopathology report, diagnosis of angiokeratoma circumscriptum of foot was confirmed. She then underwent successful surgical excision of the lesion.

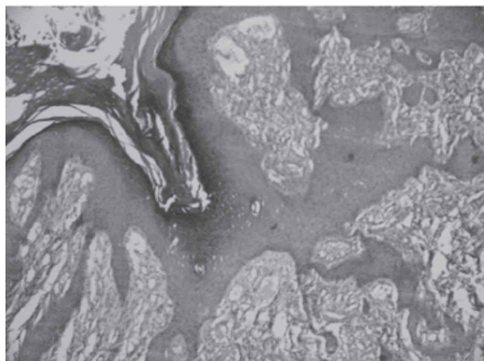

FIG. 3 - Microscopy of skin shows acanthosis, hyperkeratosis and elongated rete-ridges with underlying dermis showing congested capillaries (H&E, × 40).

Discussion

Angiokeratoma circumscriptum is a rare capillary-lymphatic malformation. It is also known as angiokeratoma corporis circumscriptum naeviforme. Among several variants of angiokeartomas, angiokeratoma circumscriptum is the least common one. There is female predominance (3:1)[4]. It is one of the rare condition comprised of a hyperkeratotic vascular plaque, usually present at birth but age of presentation may vary and it can present in a child or in adulthood. Angiokeratoma may be associated with Klippel-Trenaunay syndrome, Weber syndrome, Cobb syndrome and other mixed vascular malformations[5]. They are bluish-black in colour andover time lesions may darken in colour and change shape and size. They are commonly present on lower extremities, but may occur elsewhere on the skin. Recent literature showed them to be present on buttocks, tongue, penis, neck and even in the oral cavity[6]. The lesion becomes more verrucous with age and may bleed on trauma[1]. They may be linear or zosteriform pattern[5]. In our case the lesion started on the dorsal aspect of the right foot extending to the sole till the midline showing a zosteriform pattern involoving the $L_{4,5}$ segment. The size of lesion will determine the therapy used. Small lesions can be treated with curettage, cryocautery, electrocautery and larger lesions require laser removal or excision[1]. We report this case to be rare as angiokeratoma cicumscriptum had zosteriform presentation involving the $L_{4,5}$ dermatome of the foot.

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CASE REPORT

Giant Myxoid Liposarcoma Of Thigh- A Clinical Challenge

Jain P, Patond KR*, Borle S*, Kamble AT #*

ABSTRACT

Liposarcoma is a malignant tumor that arises in fat cells in deep soft tissue such as inside the thigh or in the retroperitonem. We are reporting here a case of giant myxoidliposarcoma of the right thigh in a 50 years old male patient. Our case is rare because of its massive size, age at the time of presentation, and the histopathology. The tumor may look very indolent due to the presenting symptoms and the clinical features on examination. Therefore establishing the correct diagnosis with the help of the imaging modalities and histopathology is necessary for the treatment and the prognosis of liposarcomas. Surgery is the mainstay of treatment. The goal should be wide local excision with healthy margins. The role of chemotherapy and/or radiotherapy in the treatment of soft tissue sarcomas remains controversial

Key Words : *Sarcoma, MyxoidLiposarcoma, Round cell sarcoma*

Introduction :

Liposarcoma is a malignant tumor that arises in fat cells in deep soft tissue such as inside the thigh or in the retroperitonem.[1] They are typically large bulky tumours which tend to have multiple smaller satellite lesions extending beyond the main confines of the tumor.[2] Liposarcoma like all sarcomas are rare. Liposarcoma is one of the most common subtypes of sarcoma constituting 9 to 18% of all sarcomas[3]. Peak incidence is between 4th and 5th decades of life with slight male preponderance. There are four types of liposarcomas of which myxoid/round cell is more common and prevalent.[4]

It characteristically occurs in extremities especially in thigh which comprises two-third of the myxoid liposarcomas4.Patients usually note a deep seated mass in the soft tissue. Only when the tumor is very large, do symptoms of pain or functional disturbances occur.

Myxoid liposarcoma tends to affect the younger patients and follow a rather aggressive clinical course leading to death. We are reporting here a case of giant myxoid liposarcoma of the right thigh in a 50 years old male patient.

Our case is rare because of its massive size, age at the time of presentation, and the histopathology.

Case Report

A 50 year old male presented to us with huge swelling over right thigh since last 8-9 months. The swelling started in the proximal thigh and then increased gradually over a period of time. At the time of presentation to us ,it extended from proximal thigh approximately 1 inch below the greater trochanter to proximal leg (Fig.1). The mass was non tender, partially

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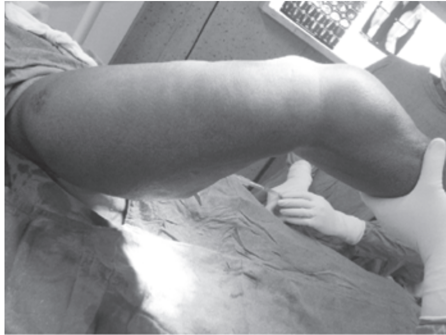

FIG.1 : *Clinical picture showing the extent*

mobile and had variable consistency. It was fluctuant and surrounded the thigh over the anterior, lateral and posterior aspect. Over the leg it was present on anterolateral aspect. The patient had no other complaints besides the size of the tumor.

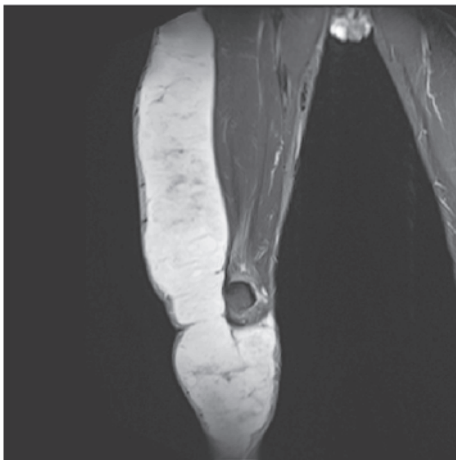

FIG.2 : *MRI of right thigh*

There were no pressure symptoms due to the bulk of the tumor. There were no obvious clinical features of tumor at any other site and X-ray chest was normal. X-ray of the thigh showed only soft tissue swelling. MRI of the thigh was done (Fig. 2) which showed a subcutaneous soft tissue mass of 49cm x 11cm x 7.6cm. It stated that the lesion is predominantly solid with few interspersed areas of cystic lesion. The fat plane was well preserved and the lesion was abutting the vastus lateralis muscle and illiotibial band laterally and and the semitendinosis anteriorily.

FIG.3 *: Excised tumor mass*

Interosseous membrane appeared normal. The patient was operated under spinal anaesthesia and excision of the tumour was done. Approximately 90% of the visible tumour (Fig. 3) was excised and we had to abandon the procedure because of hypovolaemic shock. Gross pathology was consistent with MRI findings.The tumor was highly vascular and we had to transfuse five units of blood. He was again taken for surgery after 5 days and residual tumour was removed. This time also even without significant blood loss the patient went into hypovolaemic shock, probably due to the release of vasoactive substances from the tumor mass. A part of the excised tumor was sent for the biopsy and the pathologists reported it as Myxoid Liposarcoma(Fig.4). Looking at the size of the tumor, we expected to see a large number of round cells, and had requested the pathologist to specifically to report about the percentage of round cells. They reported that the number of round cells is less than 5%.

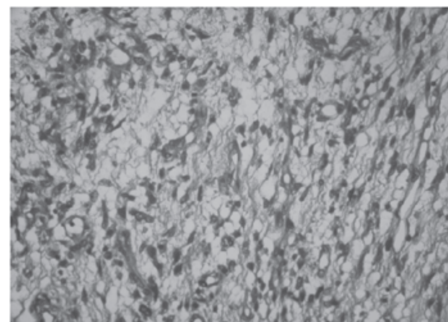

FIG. 4 : *Photomicrograph showing undifferentiated round cells and lipoblast at places crow's feet vessels are seen. (H & E X 40)*

Delayed suture removal was done and the patient is under follow up for local radiotherapy and systemic chemotherapy.

Discussion

The tumor may look very indolent due to the presenting symptoms and the clinical features on examination. Therefore establishing the correct diagnosis with the help of the imaging modalities and histopathology is necessary for the treatment and the prognosis of liposarcomas.

The World Health Organization Classification of Tumors [6] divides liposarcoma in four main histological types: well-differentiated, myxoid, round cell and pleomorphic types. As myxoid and round cell tumors share the same cytogenetic abnormalities, namely the translocation t(12;16)(q13;p11) leading to the fusion of the genes *DDIT3* and *FUS* with generation of a hybrid protein *FUS/DDIT3*, some authors consider both lesions as a continuum of the same disease[7]. This possibility seems to be supported by the frequent finding of areas of round cells in myxoid liposarcomas, which has been considered a marker of poor prognosis when representing 5% or more of the mass in localized myxoid liposarcoma. In our case the amount of round cells was less than 5%.

Previous reports have shown metastases of Myxoid round cell sarcoma (MRCL) to extra pulmonary sites, including the retroperitoneum, subcutaneous soft tissue and bone[5,8,9,]. Antonescu and Blair reported that MRCL in particular tends to spread to other soft tissue sites including retroperitoneum, thorax, and extremity before metastasizing to the lung[10,]. Also, in the previous large series of MRCL, extra pulmonary metastatic rate in MRCL was 17-30% and common sites of extra pulmonary metastases were bone, soft tissue of extremity, retroperitoneum, abdomen, and chest wall[5,8,9]. Skeletal metastasis has recently been reported as the most common site of metastasis in MRCL [5].

We had performed an ultrasound examination of abdomen and pelvis, which was normal and there was no obvious clinical sign or symptom of skeletal metastasis.

Surgery is the mainstay of treatment. The goal should be wide local excision with healthy margins. The role of chemotherapy and/or radiotherapy in the treatment of soft tissue sarcomas remains controversial[11]. Randomized clinical studies have produced conflicting results; some showing clear advantage in overall and/or disease-free survival, while others show no survival benefit from adjuvant therpy.[11] The consensus is in favor of adjuvant chemotherapy in high grade sarcomas. Edmonson et al from the Mayo Clinic using adjuvant chemotherapy reported delay in the appearance of distant metastasis with no survival benefit[12]. The International Union Against Cancer (UICC) and the American Joint Committee on Cancer (AJCC) recommend its use in stage III extremity or trunk sarcomas (i.e. >5 cm, grade ¾, located deep to the superficial fascia and with no evidence of metastasis) after definitive local treatment.[13] Chemotherapy and/ or radiotherapy may be indicated in cases of systemic disease, high grade tumor, not resectable tumors or positive free margins.[14]

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METHODS & DEVICES

Video Inguinal Block Dissection : A Minimally Invasive Procedure With Less Morbidity

J. Gnanraj

Introduction

Enlarged lymph nodes in patients with penile cancer are common and may be the result of infection rather than cancer. If palpable enlarged lymph nodes exist three or more weeks after removal of the primary lesion on the penis, a procedure should be considered to remove lymph nodes from one or both groins.

However these procedures are associated with high morbidity due to infection, skin necrosis, wound breakdown and chronic edema. Hence Catalona proposed a modified lymphadenectomy to reduce the morbidity and to preserve the therapeutic benefit. However this did not significantly reduce the morbidity.

We describe a minimally invasive procedure using the video assisted technique and vessel sealing system that significantly reduced the morbidity of the procedure

The Method

A triangular area is chosen for dissection with Pubic tubercle, anterior superior iliac spine and midway between them about 20 cm below the line joining those two points as the 3 angles of the triangle.

The steps are

1. Creation and dissection of surgical space
2. Identification of landmarks
   - Inguinal ligament
   - Spermatic cord
   - Saphenous vein and tributaries
   - Enlarged nodes
3. Superficial inguinal adenectomy
4. Specimen extraction

The dissection is started with the lower incision and once the places of dissection are made with blunt dissection initially. With insufflation two working ports are placed on the sides along the line of the triangle and dissection proceeds upwards.

However for those not familiar with pure laparoscopic dissections retractors could be used to lift the skin while doing the dissection and a small incision near the upper border of dissection could be used to ligate the veins.

The use of vessel sealing device seals the lymphatics too and helps in reducing the morbidity of the procedure.

Results

Two patients underwent the procedure at Bethesda Hospital Aizawl. Mr. P was a 58 year old man and Mr. L was a 63 year old man. Both of them had initial partial amputation of penis and on confirmation of the diagnosis laparoscopic pelvic lymph node dissection followed by video assisted inguinal lymph node dissection.

Both of them were discharged on the 10th postoperative day with primary healing of all the wounds. At 8 months follow up Mr. L was doing well with no recurrence. At 1 year 4 months follow up Mr. P had stenosis of the urethral meatus and opted for total amputation of the penis a month ago and is also doing well now without any recurrence

Figure 1 : *Patient L surgery in progress*

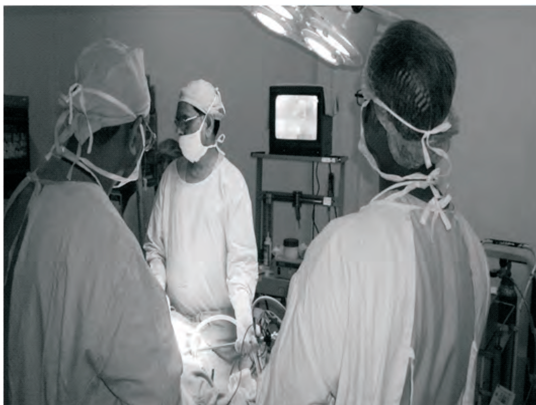

Figure 2: *Patient P surgery in progress*

Discussion

Traditionally, the inguinal region is divided into four sections by a horizontal and a vertical line drawn through the fossa ovalis. According to Daseler et al, the superficial group is divided into five natomical subgroups with the central zone being located at the confluence of the greater saphenous vein and the femoral vein. The four other zones are described as lateral superior, lateral inferior, medial superior, and medial inferior (Fig. 3). In penile cancer, mostmetastatically involved nodes are found in the upper and medial sections of the traditional four section template (ie, the medial superior group of Daseler). Matters are complicated by the fact that penile lymphatic drainage in patients with penile cancer is to both inguinal sides in up to 81% of cases.

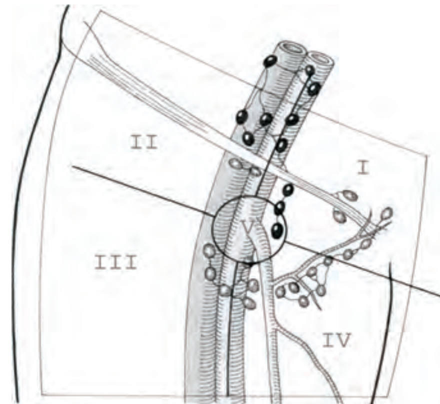

Fig. 3 - *Lymph drainage regions of the inguino-femoral region according to Daseler et al. The region is divided into five zones: one central zone (V), superior (I) and inferior (IV) medial zones, and superior (II) and inferior (III) lateral zones.*

RADICAL INGUINAL LYMPHADENECTOMY :

Radical dissection of the inguinal region is performed from the superior margin of the external ring to the anterior superior iliac spine, laterally from the anterior superior iliac spine extending 20 cm inferiorly, and medially to a line drawn from the pubic tubercle 15 cm downwards (Fig. 4). The long saphenous vein is divided, the anterior aspects of the femoral vessels are dissected, and later the femoral vessels are covered by the sartorius muscle. Thus, the superficial lymph nodes in all five anatomic zones described by Daseler (Fig. 3) and the deep inguinal nodes are dissected.

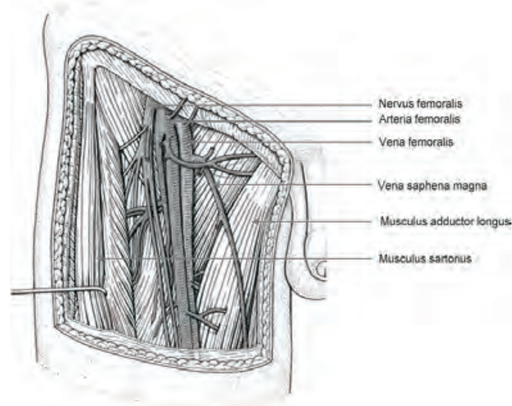

Figure 4

Bilateral ilio - inguinal block dissection is a surgery that we dreaded as a post graduate registrar because invariably all the wounds got infected and the patient stays for months and needed frequent change of dressings.

Modified Inguinal Lymphadenectomy.

Catalona proposed a modified lymphadenectomy to reduce the morbidity and to preserve the therapeutic benefit. The main points are a shorter skin incision and limitation of the dissection (exclusion of the area lateral to the femoral artery and caudal to the fossa ovalis), preservation of the saphenous vein, and no transposition of the sartorius muscle. The morbidity of this procedure is reduced compared with radical lymphadenectomy. Reducing the field of dissection increases the possibility of false-negative cases. Only a few studies which looked at this aspect of modified inguinal lymphadenectomy with small patient numbers have been reported

Video Endoscopic Lymphadenectomy:

This recently described technique is derived from laparoscopic surgery and has been evaluated only in small pilot studies. It seems to carry a lower risk of skin complications but a higher risk of lymphocele formation (23%) compared with an open approach

The video assisted inguinal block dissection and laparoscopic iliac lymph node dissection helps in reducing the morbidity especially if we use the vessel sealing system.

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Obituary

Prof. N Rangabashyam,
FRCS

I was very sad to read that **Prof. N. Rangabashyam** died peacefully in his sleep on 14th July 2013, in his home in Chennai. He was 79 years old.

Though he was not a member of the ARSI, the ARSI and Rural surgeons of India have a special reason to feel sad on his demise. Many presidents of ASI in the past had paid lip sympathy to rural surgery in India and to the 'good work' being performed by rural surgeons, but Prof. Rangabashyam was the first ASI president that took a proactive step to focus the attention of Association of Surgeons of India (ASI) on to rural surgery and to incorporate the concept of rural surgery in the activities of the Association of Surgeons of India.

Prof. Ragabashyam was the President of ASI in 1987. I was the chairman of the Karnataka State Chapter of ASI in the same year. He was the chief guest for the annual conference of our state chapter. When he realised that I had double FRCS qualification, he wondered why I was practicing surgery in a remote place (Shimoga) which did not have any facilities! I brought to his notice the difficulties that I have had to face there, and that though ASI had many 'rural' surgeons like me, practicing in rural India, there were hardly any programmes of ASI that gave solutions to the rural surgeons' problems. I even told him that the various constraints of rural surgical practice could be better addressed with the help of rich pool of knowledge, experience and resources of ASI. He was honest enough to express that he was totally unaware of any of this, and that indeed ASI needs to seriously look in to it. On his return to Chennai he promptly formed the Rural Health Care Committee (RHHC) of ASI in 1987, the first and a very important step taken by ASI to reach out to the rural surgeons. That is how the first seed of Rural Surgery was sowed in ASI. He also surprised me with a telegram that I was to be the chairman of this committee. During his conference in Chennai, he accommodated a seminar wholly devoted to the rural surgery! (thanks to the chairman of the programme committee, Dr. T.E.Udwadia too). This seminar brought together many practicing rural surgeons like Dr. R.R.Tongaonkar, Dr. J.K.Banerjee and others who have played such active roles in promoting rural surgery. Later activities of RHHC brought us face to face with Dr. Balu Sankaran, retired D.G.H.S. Govt of India, who later became our Charter president of ARSI, and late Dr. N.H.Antia the famous plastic surgeon, who became the second president of the ARSI. After that initial move, rural surgery became recognised more and more by many professional bodies leading to the formation of Association of Rural Surgeons of India and later to the formation of the Rural Surgery Section of A.S.I. and even International Federation of Rural Surgery. I for one am very happy for the sake of

rural surgery that fate brought Prof. Rangabashyam and me together, and am immensely sorry that he is no more.

He was a kind man with a friendly disposition. Many members of ARSI have fond memories of their association with this great personality.

He was a well known specialist of gastro-enterology and proctology. He had many 'firsts' to his credit: ostomy department, enterostomal therapy department for nurses, staplers in surgery in India, etc. Being a specialist in gastro-enterology,he was appointed as Professor of Gastroenterology in 1974 and went on to start the first gastro-enterology department and also the first M.Ch. course in surgical gastroenterology. His contributions on colitis, bowel cancer, other gastro-intestinal cancers, portal hypertension and bowel disease in the tropics have had a major impact throughout the world. He has contributed to and published various articles on liver surgery, pancreatitis, ileal and colonic diseases. He is one of the pioneers in the field of pancreatic and hepatobiliary surgery in India. He was appointed as the Honorary Surgeon to the President of India, by former President of India, Mr. R. Venkataraman and was a consultant surgeon to India's Armed Forces Medical College.

Among other things he was Member-Advisory panel for Gastroenterology Surgery, National Academy of Medical Sciences (India), New Delhi and Member, Permanent Committee for fixation of fee structure for Private Professional Educational Institutions in Tamil Nadu, Chennai.

He was also elected as a Fellow of the Association of Surgeons of Great Britain and Ireland, Academy of Medical Sciences, India and Academy of Medical Sciences of Singapore. Despite all this he always found time to teach and was very popular with his students.

He was awarded Padmabhushan in 2002 and Dr. B.C.Roy National award twice. His name is inscribed in the Wall of Honour of the Royal Society of Medicine, Edinburgh. He received the Living Legend award from the Chief Minister of Tamil Nadu in 2010. The list of honours received by him is longer still.

He was a student of Madras Medical College and a Fellow of Royal College of Edinburgh (FRCS E). He played a key role in getting FRCS E examination to be conducted in India from 1995.

In his death we all have lost a dear friend of rural surgery

R.D.Prabhu, FRCS. FRCS E, FARSI,
Past president ARSI
Charter president IFRS
First Chairman Rural Health Care Committee ASI
(Later named Rural Surgery Committee),
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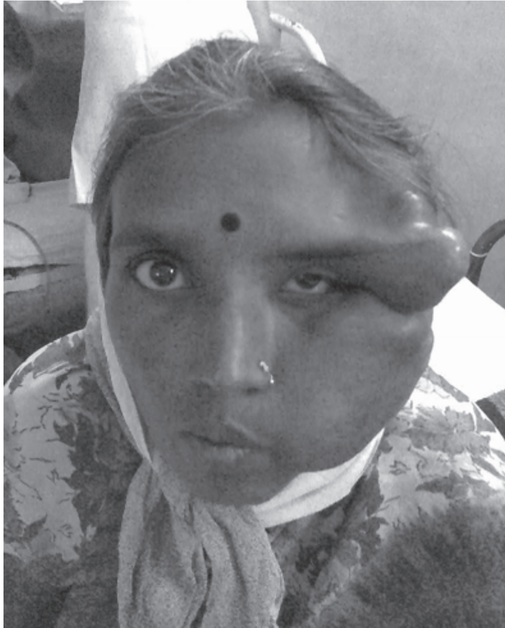

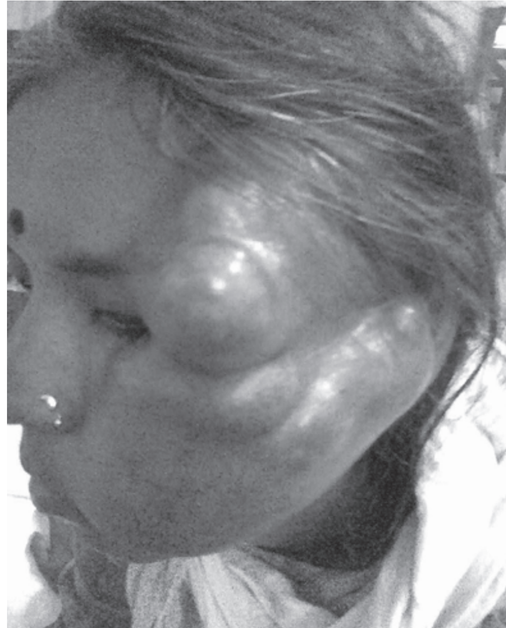

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