The Intra-Operative Use of Mobile Phones; why is there a Controversy?

Dear Editor,

Bhattacharya’s article does not completely address the risks that surgeons pose to their patients if using mobile phones in an operating theatre environment. Previous studies have demonstrated that, apart from well-investigated effects of electro-magnetic interference, which has been documented in association with mortality, there is a significant potential infection control risk.

The basis, as previously suggested, that prolonged mobile phone use may be stimulatory towards cerebral function is unproven in regards to surgical practice and is contrary to the practical experiences of anyone who has tried to operate in an environment demanding high mental concentration and performance. Similar concentration is required when driving and when drivers use a mobile phone there is an increased likelihood of a crash resulting in injury. The use of a hands-free phone was not proven to be any safer.

There should not be a controversy in regards operative mobile phone use. A sensible and considered approach would imply that the theoretical benefits to the operator of processing this technology are outweighed by the practicalities of distraction and documented dangers as above.

In addition, this new technology changes the normal standards of operative care and given the published complications, in the absence of proven benefits, are there not patient consent and medico-legal issues to consider in regards to ‘our inseparable and trusted companion’?

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REFERENCES


Laparoscopic cholecystectomy in a patient with situs inversus

Dear Editor,

Laparoscopic cholecystectomy has become the gold standard for treatment of calculous cholecystitis. We describe a case of laparoscopic cholecystectomy performed in a patient with Situs Inversus.

A 40-year-old lady, presented with recurrent pain epigastrium; initially the radiation was nonspecific but subsequently pain was mainly in the left upper quadrant. Physical examination revealed only tenderness in the left hypochondrium and dextrocardia. Routine investigations revealed no abnormality except dextrocardia confirmed on chest X-ray.

Ultrasonography and CT-scanning revealed the diagnosis of situs inversus along with calculous cholecystitis. Laparoscopic cholecystectomy was done, to enable the patient to get the accepted benefits of laparoscopic surgery. Accordingly, the following changes were made in the OT-setup and the operation:

- The surgeon and the assistant at the telescope stood on the right of the patient and the other assistant on the left
- The monitor was placed behind the left shoulder of the patient.
- The umbilical and substernal ports were placed as usual but the telescope had to be introduced towards the left upper quadrant; the trocar of the substernal port had to be angled towards the left, to the left of the left-sided falciform ligament. The two other ports were also introduced as usual except that these were on the left side of the abdomen and
not the right.

The following difficulties were encountered:
• Adhesiolysis was difficult due to fear of inadvertent damage to the unusual anatomy.
• The gall-bladder was having to be held by the right hand by the grasper while dissection was being carried out by the left hand. At times the instruments had to be reintroduced through opposite ports to allow dissection to proceed by the more convenient hand!
• The CBD was to the right of the Calot’s triangle and not the left and this required constant mental concentration and reorientation.

However, though a bit prolonged the operation could be completed without mishap. Postoperative recovery was uneventful as has been follow-up.

Situs inversus is a rare, autosomal recessive condition with an incidence of 1/10,000;\(^1\) clinical diagnosis is problematic but modern imaging procedures such as USG usually suffice to diagnose gallbladder disease and as in our case, also reveal the transposition. Laparoscopic cholecystectomy has been rarely reported in situs inversus (total 22 reports found on Pubmed Search) with the first case being reported in 1992\(^2\), Indian references being few\(^3,4\). All authors have commented on the rarity of the condition\(^4,5\) and have stressed that the procedure requires mental reorientation to the altered spatial relationships of the structures and necessitates reorientation of hand-eye coordination too.

In conclusion laparoscopic cholecystectomy in a patient with situs inversus is difficult due to the unfamiliar spatial orientation of structures. The operation requires mental reorientation and readjustment of the usual hand-eye coordination. However, despite all this, it is still quite feasible and safe, and should be offered to these otherwise normal patients.

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REFERENCES


Eosinophilic ascites

Dear Editor,

Eosinophilic gastroenteritis is an inflammatory disease of unknown etiology characterized by infiltration of the gastrointestinal tract with eosinophils, accompanied by varying abdominal symptoms and usually by peripheral blood eosinophilia.\(^1\)

A 41-year-old man presented with abdominal distension and postprandial abdominal fullness for 3 weeks. There was no history of fever, abdominal pain or vomiting. He had no history of worm infestation. There was no history of swelling of feet or jaundice. He had no significant medical or family history and was a non-smoker and alcoholic. Physical examination showed presence of ascites. There was no stigma of chronic liver disease.

Investigations showed peripheral eosinophilia with absolute eosinophil count was 2100/mm\(^3\) with elevated ESR of 54. Routine biochemical investigations were normal. Stool examination was normal. Ultrasound abdomen showed moderate ascites. Ascitic fluid analysis showed low serum ascites albumin gradient (SAAG = 0.7), high protein fluid with elevated eosinophil count of 8350 /mm\(^3\). CT scan abdomen showed moderate ascites with thickening of jejunum. Push enteroscope passed 150 cm in jejunum, which showed edematous mucosal folds of jejunum. Biopsy from jejunal mucosa showed mucosal and submucosal infiltration of eosinophils. Plain radiograph chest