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Division of Surgery
Faculty of Medicine and Health Sciences
University of Stellenbosch

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Report: HPBASA Abbott Laboratories Travelling Fellowship 2018

Thank you to Abbott Laboratories and the adjudication committee of HPBASA for awarding the 2018 Travelling Fellowship to me.

This enabled a three week visit to the Service du Chirurgie Digestive Hepato-Bilio-Pancreatique et Transplantation Hepatique of the Pitié Salpêtrière Hospital in Paris from 10 September to 2 October 2018. The opportunity came about after an invitation from Professor Olivier Scatton, who attended the 2017 HPBASA Congress in Pretoria.

The Pitié Salpêtrière Hospital, originally a gunpowder factory in the center of Paris, dates back to the latter part of the seventeenth century and has an illustrious, yet storied history. The hospital was initially a refuge for the prostitutes, epilleptics, the homeless and the destitute of Paris, until by royal decree the conditions became more sanitary. The interesting nature of the varied inhabitants of the institution led to closer observation by subsequent personnel, which laid the foundations of the science of neurology and psychiatry by pioneers such as Charcot, Babinski, de la Tourette and Freud.

Today the hospital caters for all specialities and is one of the three largest hospitals in Europe and was the site of the first liver and first heart transplant in France. The position of largest hospital varies from year to year between Pitié, Lille and Charité in Berlin. The hospital forms part of the 39 hospital network of the Assistance Publique Hôpitaux de Paris (APHP) and acts as a nationwide referral centre for HPB Surgery and Liver transplantation. An interesting fact of the French Public Health system is that

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neither geography, nor proximity influence treatment location and that reputation and prestige play an important role in gaining referrals.

The Digestive Surgery Service occupies its own building in the greater compound with four dedicated operating theatres, an outpatient consultation wing, wards and 14 bed intensive care unit. It is ranked in one of the top three positions in France regarding quality of care and outcomes for liver transplantation, HPB Surgical Oncology, Colorectal Surgery and Upper GI Surgery. The anaesthetic and critical care staff are dedicated to this Service.

The Service is under the leadership of Professor Jean-Christophe Vaillant, who performed most of the pancreatic operations I observed. The four theatres run at full capacity for five days a week and the amount of major surgery performed annually is impressive; 110 liver transplantations, 250 major liver resections. During my stay I observed five pancreatico-duodenectomies, a laparoscopic left pancreatectomy, seven major liver resections of which two were by laparoscopy and eight liver transplants.

Due to the volume of surgery performed and the flood of referrals, three separate multidisciplinary discussion sessions are scheduled each week; for primary liver lesions, liver transplant and GIT Surgical Oncology. The sessions also only start at 16:30 and end when all patients have been discussed. The primary liver meeting discusses between 20 and 30 patients every week and the Oncology meeting discussed from 40 to 60 patients per meeting during my visit. Liver surgery decisions were based on MRI findings.

Multidisciplinary oncology decisions are mandated by French law and the attendees and decisions of each meeting are carefully recorded. This information is immediately available in electronic format to the referring clinician and other staff. The discussions were robust and lively, considering that each speciality have the latest modalities and regimens available to them. It was also interesting to note that in the majority of cases, patients were either elderly or afflicted by co-morbid conditions.

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An aggressive approach to pancreatic surgery for adenocarcinoma is evident and the use of neo-adjuvant Folfirinox is commonplace at the institution. The routine pancreatico-duodenectomy includes an interaorta-caval nodal dissection and total clearance of the tissue in the angle between the superior mesenteric artery, proximal common hepatic artery and aorta. A learning point for me was the reluctance to use energy/sealing devices in the retroportal dissection after neo-adjuvant chemo-radiation due to their experience of late onset major arterial bleeds after discharge from hospital in seemingly uncomplicated cases.

An obvious question was their experience with laparoscopic pancreatico-duodenectomy. They have done two cases and have since decided not to pursue this technique for the foreseeable future. Considering that the Service is very experienced in advanced laparoscopic surgery, it reinforced my view that a balanced approach to laparoscopic surgery remains important.

The liver resections performed by Professor Scatton were a pleasure to observe. The anaesthesia, such a critical element in liver surgery, was exacting and utilised trans-oesophageal echocardiography to judge fluid status and guide central venous pressure management. The resections were anatomic and followed meticulous portal and pedicle dissections. Intra-oparative ultrasound was used throughout the resection. The hanging technique is used almost routinely and adapted to each resection. The Pringle manoeuvre is employed liberally, the resections virtually bloodless and no ischaemic liver is left behind after a resection. This minimises biliary fistulas in their opinion and drains were not placed.

The laparoscopic resections were major and were an exact duplication of their technique for open resections in terms of selective extrahepatic inflow control and parenchymal division. 3D Laparoscopy was routine during all of the major laparoscopic work I observed. The laparoscopic technique is considered in all cases but the approach is balanced and takes into consideration body habitus, previous surgeries, parenchymal health, variant anatomy and tumour location. Professor Scatton stressed the importance of the extrahepatic portion of the right portal vein as a landmark during laparoscopic portal dissection and that portal vein embolisation has to preserve this portion.

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Although the service functions in French, I was able to follow the discussions, decision-making process and proceedings in theatre. I was impressed by the long hours that the staff spend at the hospital and the volume of work that is performed on a weekly basis. Despite this clinical pressure, every contact and procedure generates data that are captured on various databases, which leads to benefits such as Pitié Salpêtrière Hospital being involved in 2500 scientific publications in 2017.

The surgeons are highly competitive and want to be known for being the busiest and best Unit in the country. The balance between offering surgical treatment to most referrals and maintaining very low peri-operative morbidity and mortality figures as a measure of quality mandates dedication and consistency. This vision is shared by the management of the hospital and the APHP! Being witness to these standards will serve as a lifelong inspiration.

Professor Scatton and his staff made my visit extremely informative and rewarding. I was made to feel welcome at every turn and I endeavour to maintain a strong relationship in the future.

Thank you for the opportunity to gain such valuable insights and experience HPB Surgery at its best!

Yours sincerely

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