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Editor's note

Global Medical Robotics Market 2014 - 2020

Surgical Robot, Rehabilitation Robotics, Telemedicine, Assistive Robots, Orthotics, Prosthetics, Radio Surgery, Exoskeleton

Advances in healthcare technology over the years have showed tremendous growth. From surgical devices to radio imaging and treatment methods, all aspects of medicines have taken technological leaps in the recent decades, making healthcare technology one of the most lucrative markets. The demand for robotics in healthcare, especially surgical procedures is increasing. Robotic procedures are deemed safer in situations where humans might make errors, as robotic procedures have far greater precision and leave minimum margin for error, and therefore having robotic systems in a hospital would be able to generate more revenue. Robots can also create better clinical outcomes and curtail labour costs, leading to an exponential growth in demand.

However, surgery is not the only field with robotic advancements. Robotic panels are found in all segments of healthcare, such as sanitation and for disinfecting purposes, sterilization of instruments, processing laboratory supplies and other fields where technology aids and can replace human effort. Robotics in medicine is viewed as an all-round technological advancement, which is not limited to only one section. This is potentially the biggest leap in technology for the healthcare industry since the introduction of IT and has the scope of commercially being a vibrant industry with extensive chains of supply, production and R&D development.

This technology, however, is limited to economies that are invested in medical care to a great extent. For instance, the possibility of investment into robotic arms to enhance surgical procedure in public hospitals in a developing country such as Ghana is unlikely but the developed economies of North America and Europe are the most lucrative markets for medical robotics as they have significantly invested in healthcare. However; Asian countries such as India and China are the markets of the future as the governments of these countries are putting in efforts to improve healthcare and the economies will show a significant growth.

Dr Pradeep Bhardwaj
Editor-in-Chief

Have an insightful reading.
Your suggestions are most welcome!
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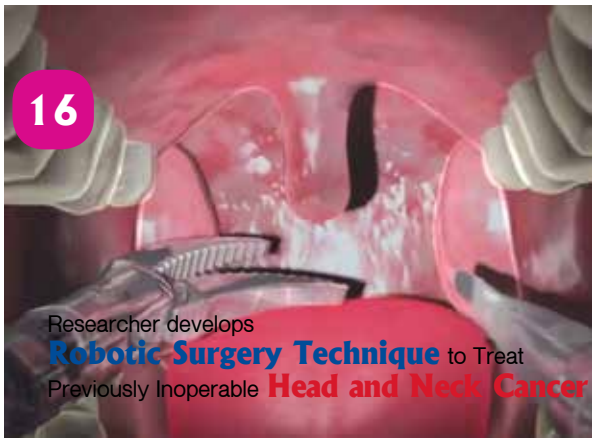


Researcher develops
Robotic Surgery Technique to Treat
Previously Inoperable **Head and Neck Cancer**

Minimally Invasive Esophagectomy Improves Outcomes
But Remains Underutilized

Hernia- Treatment
Remedies and New Innovation

AIROX Technologies

Airox Technologies Pvt. Ltd. Receives Fastest Growing Indian Company

Excellence Award - 2014

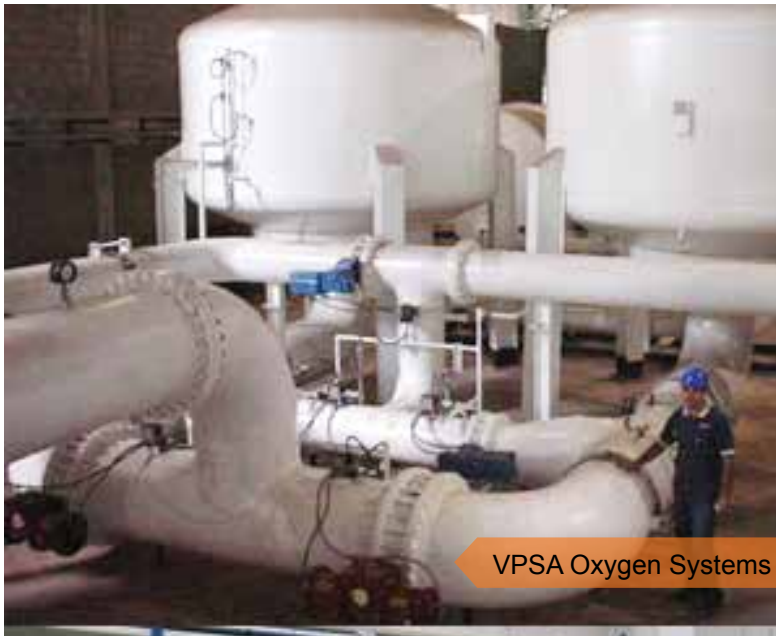
Airox Technologies Pvt. Ltd., a leading provider of Oxygen Generators, today had received the Fastest Growing Indian Company Excellence Award – 2014 on the occasion of 6th International Achievers Summit on Global Corporate Achievements & Social Responsibilities, Bangkok - Thailand. The award was presented to **Airox Technologies Pvt. Ltd.** By Former Deputy Prime Minister of Thailand H.E. Mr. Korn, Former chief Justice & Governor, O.P. Verma at International Achiever Conference held at Holiday Inn, Bangkok, Thailand. International Achievers Conference (IAC) concentrates on the theme "how the successful Achievers can help the social & economic in-

frastructural development in and around the country." It will provide examples of social entrepreneurs and successful models of the society and corporate sector partnership. Jury has finalized **Airox Technologies Pvt. Ltd.** by seeing overall growth in phenomenal turnover, profit, employees, clients & impact made in overall betterment of society.

Airox Technologies Pvt. Ltd. Has continually demarked itself by the quality of its oxygen generators. The product has significantly contributed to improving the way hospitals use oxygen. The product has also significantly contributed in cost cutting and in ensuring more safety.Thus the oxygen generators tremendously helps in cost saving (up to 65 -70%), safety, time management and reduction in losses.

Airox Technologies Pvt. Ltd. Now plans to expand its market reach on the wide recognition its product has gained in the market. Our objective is now to provide best in quality but economical oxygen to patients & improve hospital economy by giving effective alternative for expensive & combustive liquid & cylinder oxygen.

Airox TechnologiesPvt. Ltd. is a highly skilled team of professionals serving hospital & medical industry from last 12 years along with its sister concern S.A. Medical Systems. With complete infrastructure in place we are serving PAN India though our strong team of 60 employees and 20 distributors across India. Airox now is number one PSA oxygen generator supplier in India. This milestone is been achieved by combination of great quality of Airsep Oxygen Generator (World's Largest Manufacturer of PSA Oxygen Systems), expert team for sales and service. Airox has also received numerous awards. For more information about **Airox Technologies Pvt. Ltd.**, visit its website at ***www.airoxtechnologies.com.***



VPSA Oxygen Systems

Oxygen Feed Gas Generators

HOSPITAL INFRASTRUCTURE & MANAGEMENT
EXHIBITION & CONGRESS

1st Edition of HIM concludes on a successful note

India's premiere hospital infrastructure show, Hospital Infrastructure & Management (HIM), concluded successfully with positive response from the 3256 business buyers who attended, providing the perfect platform for the exhibitor companies trying to win tenders, drive sales and increase market shares in healthcare infrastructure, construction and maintenance.

The three-day exhibition witnessed major industry players exhibiting at the show and a two-day seminar that covered cutting edge topics focusing on healthcare design and infrastructure, such as "Delivering optimum space utilisation for your hospital"; "Identifying a one stop solution for designing and building healthcare projects"; "Flooring your patients – understanding the importance of vinyl for hospitals"; "Surgical site infection: innovative solutions for tackling one of the most critical challenges facing hospitals today"" amongst various others. The seminar wasattended by VIPs fromReliance, Hiranandani, Fortis, KokilabenDhirubhaiAmbani,Hinduja, Apollo Group and other hospitals along with validated industry buyers including key budget holders for hospitals,as well as policy makers, consultants, health ministry and investors in healthcare projects.Below is feedback from some of the participating exhibitors:

"It was a nice conference and exhibition, very well organisedand much needed for the healthcare infrastructure industry." *Moulik Panchal*, *Drager*

"Participating in HIM 2014 has provided a better insight to what the local healthcare sector needs and how we can improve the quality of healthcare in India." – *Ajit Kothiwale, Stantec*

"The overall expo was very good. The response from visitors (doctors)was great. Looking forward to the expo next year." *Vijay Dalvi*, *Janak Healthcare*

"This is the first time we're exhibiting and it wasa valuable experience. HIM provided us with the opportunity and learning interface to network with the hospital industry. We thank the HIM team for a job well done and look forward to participating at HIM 2015." – *Salim Khan - Country Sales Head, Redeminet*

Having delivered a successful first show, HIM 2015 promises to be bigger and more power-packed catering to thegrowing demands of this thriving industry.

For more information contact:
Ms. Neha Bhat
Marketing Executive
Tel: 022 6171 3220, Email: neha.bhat@ideas-exchange.in

Dr. Reddy's Announces the Launch of Valganciclovir Tablets, USP

Dr. Reddy's Laboratories (NYSE: RDY) announced today that it has launched Valganciclovir Tablets USP 450 mg, a therapeutic equivalent generic version of VALCYTE® (Valganciclovir) tablets in the US market on December 15, 2014, approved by the United States Food & Drug Administration (USFDA).

The VALCYTE® (Valganciclovir) tablets brand had U.S. sales of approximately $440 Million MAT for the most recent twelve months ending in October 2014 according to IMS Health*.

Dr. Reddy's Valganciclovir tablets, USP in 450 mg is available in bottle counts of 60.

WARNING: HEMATOLOGIC TOXICITY, CARCINOGENICITY, TERATOGENICITY, AND IMPAIRMENT OF FERTILITY

See full prescribing information for complete boxed warning.

- Clinical toxicity of valganciclovir, which is metabolized to ganciclovir, includes granulocytopenia, anemia, and thrombocytopenia.
- In animal studies, ganciclovir was carcinogenic, teratogenic, and caused aspermatogenesis.

Cancer Genetics, Inc. Announces Appointment of Venkatadri Bobba to Cancer Genetics India's Board of Directors

Cancer Genetics, Inc. (Nasdaq: CGIX) ("CGI" or "the Company"), an emerging leader in DNA-based cancer diagnostics, announced today the addition of Venkatadri Bobba to Cancer Genetics India's Board of Directors.

"Mr Bobba has a tremendous track record of leadership in the life sciences. His experiences and insights will bring significant value to CG India's board of directors," said Panna Sharma, CEO and President of Cancer Genetics, Inc.

Bobba brings with him more than 36 years of corporate leadership experience in the pharmaceutical and life sciences industries. Bobba, who is currently a General Partner with Ventureast, has held executive leadership positions at a number of life sciences companies in the US, EU, and Asia. Prior to joining Ventureast, Bobba served as Senior Vice President of Operations at Aradigm Corporation and from 2001-2003 was Executive Vice President at Diosynth, a division of Akzo Nobel. From 1995 to 2000, Bobba served as President and CEO at Molecular Biosystems, an NYSE listed company. Previous to that, Bobba was Executive Vice President of Centocor Inc (now Jansen Biotech, a division of Johnson & Johnson) and held several executive positions, including President, at Warner-Lambert, Indonesia. He also previously served as V.P. of Manufacturing at Parke-Davis, USA (now part of Pfizer).

"It is an exciting time to be part of such a high-growth market like India. I look forward to the growth and much needed innovation that CG India will bring to Indian cancer patients and hospitals at an affordable price," said Bobba. "CG India has established itself as a leader in the oncology diagnostics market with a firm commitment to innovation. I look forward to helping the company offer novel cancer diagnostic tests to all patients who needs them to improve their clinical outcomes."

Venkatadri Bobba
Director, Cancer Genetics

Bobba is an active board member of three US-based companies, including Diabetomics Inc., Melior Pharma, and Sparsha Inc. Bobba also sits on the board of several Indian-based companies, including Portea, Richcore, and Sparsha Pharma, an Indian subsidiary of Napo Pharmaceuticals. Additionally, he serves on the advisory board for the SOHO Group, the largest pharmaceutical company in Indonesia, and for Cumberland Pharmaceuticals, Inc., USA, a Nasdaq listed company.

A pharmacist by training, Bobba graduated with gold medal honors from Andhra University and holds an MBA from Farleigh Dickinson University, New Jersey.

Shri Shripad Yesso Naik at CII Health Summit:

Time to Make "Health for All" A Reality

Shri Shripad Yesso Naik, MoS, Ministry of Health & Family Welfare said that it is time to make 'Health for All' a reality, here today. He stated that people of the country should have access to affordable and quality healthcare. The health strategy of the government needs to take healthcare to the doorstep of the people.The Minister stated that skilled and trained manpower formed a critical component of this strategy. Shri Shripad Yesso Naik was delivering the keynote address at the 11th India Health Summit organized by CII on the theme "Health for All: Call for Action".

The Minister highlighted the initiatives of the

Ministry of Health & Family Welfare in providing healthcare in the country, including achievements under the National Health Mission, the Universal Immunisation Programme for the children, providing healthcare services for mother and child, and addressing challenges posed by non-communicable diseases such as diabetes, cancer, hypertension etc. Shri Naik stated that significant achievements have been achievements in addressing TB and Malaria, while there are concerted efforts being made to eliminate Filaria and Kala Azar. The Minister said that efforts are being made to reduce the Out of Pocket expenses on healthcare by the common man in the country, which are substantial. The National Health Assurance Mission is a noteworthy step in this direction, he mentioned.Shri Naik stated that technology can be effectively used to bridge the geographical distance. Telemedicine is being used to address the constraints and challenges of the terrain in the country, he informed.

The Health Summit is a timely opportunity to talk on the topic of "Health for All", the Minister said. He added that all stakeholders in the healthcare sector need to work towards this aim.

Shri Lov Verma, Secretary, Ministry of Health & Family Welfare, in his address highlighted the primary pillars of the National Health Assurance Mission which include preventive and promotive healthcare; provisioning of free essential drugs, diagnostics and healthcare services; and strengthening the tertiary tier.The key concerns in healthcare in the country are equity, affordability, accessibility and quality, he noted. He stated that while we are ahead on the globalparameters in MMR, we are well on way to achieve the MDG milestone for IMR and below-five mortality rates.

The summit will have panel discussions and presentations on topics such as economics of healthcare deliver; challenges of sustainability in quality healthcare delivery; real solutions in virtual healthcare; preparing workforce for meeting the challenges in healthcare; Make in India: unlocking the potential in healthcare sector; and Swachh and Swastha Bharat: laying the foundation of a healthier India.

Present during the inaugural session of the two-day 11th India Health Summit were Dr Naresh Trehan, Chairman, CII National Committee on Healthcare; Shri Harpal Singh, Chairman Emeritus Fortis Healthcare Ltd., and Shri Rahul Khosla, Co-Chairman, CII National Committee on Healthcare.

Kimaya NICU Web Application Decreases Infant Mortality Rate

Online solution to automate formulation of infant nutritional supplements

In a joint effort with KEM Hospital and Kimaya NICU, a domain specific neonatal healthcare technology provider, neonatal ICU's now have a fully automated online platform to formulate nutritional supplements for premature infants with 100% accuracy and in a fraction of the time. **Launched on the occasion of World Prematurity Day, this platform has already shown impressive results in its pilot test stage**.

In the pilot test, deployed at Pune's KEM hospital, the Kimaya-TPN (Total Parenteral Nutrition) solution has been able to contribute in reducing the neonatal mortality rate by close to 45% due to its high performance and efficiency. The one screen application allows doctors to calculate the neonatal nutritional plan for each baby with very high accuracy, within seconds. This simply requires them to enter a set of informational data points into the application, such as body weight, additives amount, lipid requirement and other special nutritional options.

Dr. Umesh Vaidya, M.D., D.N.B. Pediatric, KEM Hospital Pune said, "Nutritional requirements of premature babies have to be calculated very accurately to avoid complications and help the baby grow. KimayaTPN application is very doctor friendly and has resulted in a huge increase in calculation speed and accuracy from the existing manual calculations. "

Expressing satisfaction at the result of their efforts, Gautam Rege, Co-Founder, Kimaya NICU had this to add, "A deep rooted desire to deliver a cutting edge solution for Neonatal ICUs enabled our team, to conceptualize, program and deploy the Kimaya-TPN Software. Since this is a life critical process with the impact of errors being fatal to neonates, the application has a number of fail-safe mechanisms to prevent erroneous entries and thus give infants a fighting chance at survival."

Given the fragility of life at the earliest levels, getting the right mix of nutrition to support life is a critical aspect in ensuring survival of premature babies. The administration of this nutritional formula must also be at an acceptable infusion rate with the correct CNR (Calorie Nitrogen Ratio) to avoid complications and fatality.

This cloud based application allows the records of infants to be accessed easily in the future and from multiple locations. The application archives infant progress on a day to day basis thus allowing doctors to plan the nutrition for each infant. The impact the application can have is huge and a further refined version of the software, based on inputs by medical experts is ready to give NICUs across the country a cutting edge tool aimed at saving infant lives.

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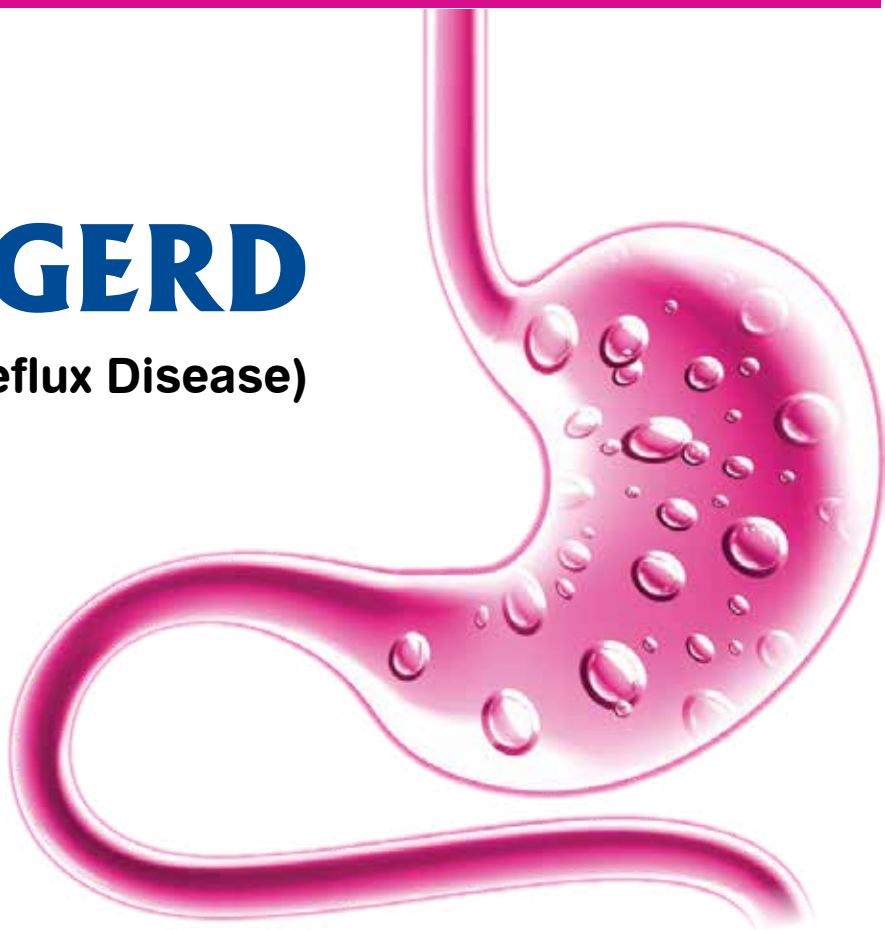
Pediatric GERD

(Gastro-Esophageal Reflux Disease)



In infants, more than 50 percent of children three months or younger have at least one episode of regurgitation a day. This rate peaks at 67 percent at four months old. But an infant's improved muscle control and the ability to sit up will lead to a spontaneous resolution of significant GER in more than half of infants by 10 months old, and four out of five at age 18 months. Researchers have found that 10 percent of infants younger than 12 months with GER develop significant complications.

Everyone has gastro esophageal reflux (GER), the backward movement (reflux) of gastric contents into the esophagus. Extra esophageal Reflux (EER) is the reflux of gastric contents from the stomach into the esophagus with further extension into the throat and other upper aero digestive regions. In infants, more than 50 percent of children three months or younger have at least one episode of regurgitation a day. This rate peaks at 67 percent at four months old. But an infant's improved muscle control and the ability to sit up will lead to a spontaneous resolution of significant GER in more than half of infants by 10 months old, and four out of five at age 18 months. Researchers have found that 10 percent of infants younger than 12 months with GER develop significant complications.

Dr. Rajiva Kumar
Child Specialist
Muzaffarpur, Bihar, India

The diseases associated with reflux are known collectively as Gastro-Esophageal Reflux Disease (GERD). Physically, GERD occurs when a valve at the lower end of the esophagus malfunctions. Normally, this muscle closes to keep acid in the stomach and out of the esophagus. The continuous entry of acid or refluxed materials into areas outside the stomach can result in significant injury to those areas. It is estimated that some 5 to 8 percent of adolescent children have GERD.

WHAT SYMPTOMS ARE DISPLAYED BY A CHILD WITH GERD?

While GER and EER in children often cause relatively few symptoms, the most common initial symptom of GERD is heartburn. Heartburn is more common in adults, and children have a harder time describing this sensation. They usually will complain of a stomach ache or chest discomfort, particularly after meals.

More frequent or severe GER and EER can cause other problems in the stomach, esophagus, pharynx, larynx, lungs, sinuses, ears, and even the teeth. Consequently, other typical symptoms can include crying/irritability, poor appetite/feeding and swallowing difficulties, failure to thrive/weight loss, regurgitation (wet burps or outright vomiting), stomach aches (dyspepsia), abdominal/chest pain (heartburn), sore throat, hoarseness, apnea, laryngeal and tracheal stenoses, asthma/wheezing, chronic cough and throat clearing, chronic sinusitis, ear infections/fluid, and dental caries. Effortless regurgitation is very suggestive of GER. However, recurrent vomiting (which is not the same) does not necessarily mean a child has GER.

If your child displays the typical symptoms of GERD, a visit to a pediatrician is warranted. However, in some circumstances, the disorder may cause significant ear, nose, and throat disorders.

When this occurs, an evaluation by an otolaryngologist is recommended.

HOW IS GERD DIAGNOSED?

Most of the time, the physician can make a diagnosis by interviewing the caregiver and examining the child. There are occasions when testing is recommended, and each test has advantages and shortcomings. Those most commonly used to diagnose GERD include:

- **pH probe**: A small wire with an acid sensor is placed through the nose down to the bottom of the esophagus, and usually left in place between 12-24 hours. The sensor detects when acid from the stomach is "refluxed" into the esophagus.
- **Barium swallow or upper GI series:** The child is fed barium, a white, chalky, liquid. A video x-ray machine follows the barium through the upper intestinal tract and lets doctors see if there are any abnormal twists, kinks, or narrowings of the tract.
- **Technetium gastric emptying study:** The child is fed milk mixed with technetium, a very weak radioactive chemical, which is then followed through the intestinal tract using a special camera. This test helps determine whether some of the milk/technetium ends up in the lungs, and how long milk sits in the stomach.
- **Endoscopy with biopsies:** This most comprehensive test involves passing a flexible endoscope with lights and lenses through the mouth into the esophagus, stomach, and duodenum. This allows the doctor to see any irritation or inflammation present. In some children with GERD, repeated exposure of the esophagus to stomach acid causes some inflammation (esophagitis). Endoscopy in children usually requires a general anesthetic.

WHAT TREATMENTS ARE AVAILABLE FOR GERD?

Treatment of reflux in infants is intended to lessen symptoms, not to relieve the underlying problem, as this will often resolve on its own with time. A simple treatment is to thicken a baby's milk or formula with rice cereal, making it less likely to be refluxed.

SEVERAL STEPS CAN BE TAKEN TO ASSIST THE OLDER CHILD WITH GERD:

- **Lifestyle changes:** Raise the head of the child's bed about 30 degrees and have the child eat smaller, more frequent meals instead of large amounts of food at one sitting. Avoid eating right before they go to bed or lie down; let two or three hours pass. Try a walk or warm bath or even a few minutes on the toilet. Some researchers believe that certain lifestyle changes such as losing weight or dressing in loose clothing may assist in alleviating GERD.
- **Dietary changes:** Avoid chocolate, carbonated drinks, caffeine, tomato products, peppermint, and other acidic foods like citrus juices. Fried foods and spicy foods are also known to aggravate symptoms. Pay attention to what your child eats.
- **Medical treatment:** Most medications prescribed to treat GERD break down or lessen intestinal gas, decrease or neutralize stomach acid, or improve intestinal coordination. Your physician will prescribe the most appropriate medication for your child. It is rare for children with GERD to require surgery.

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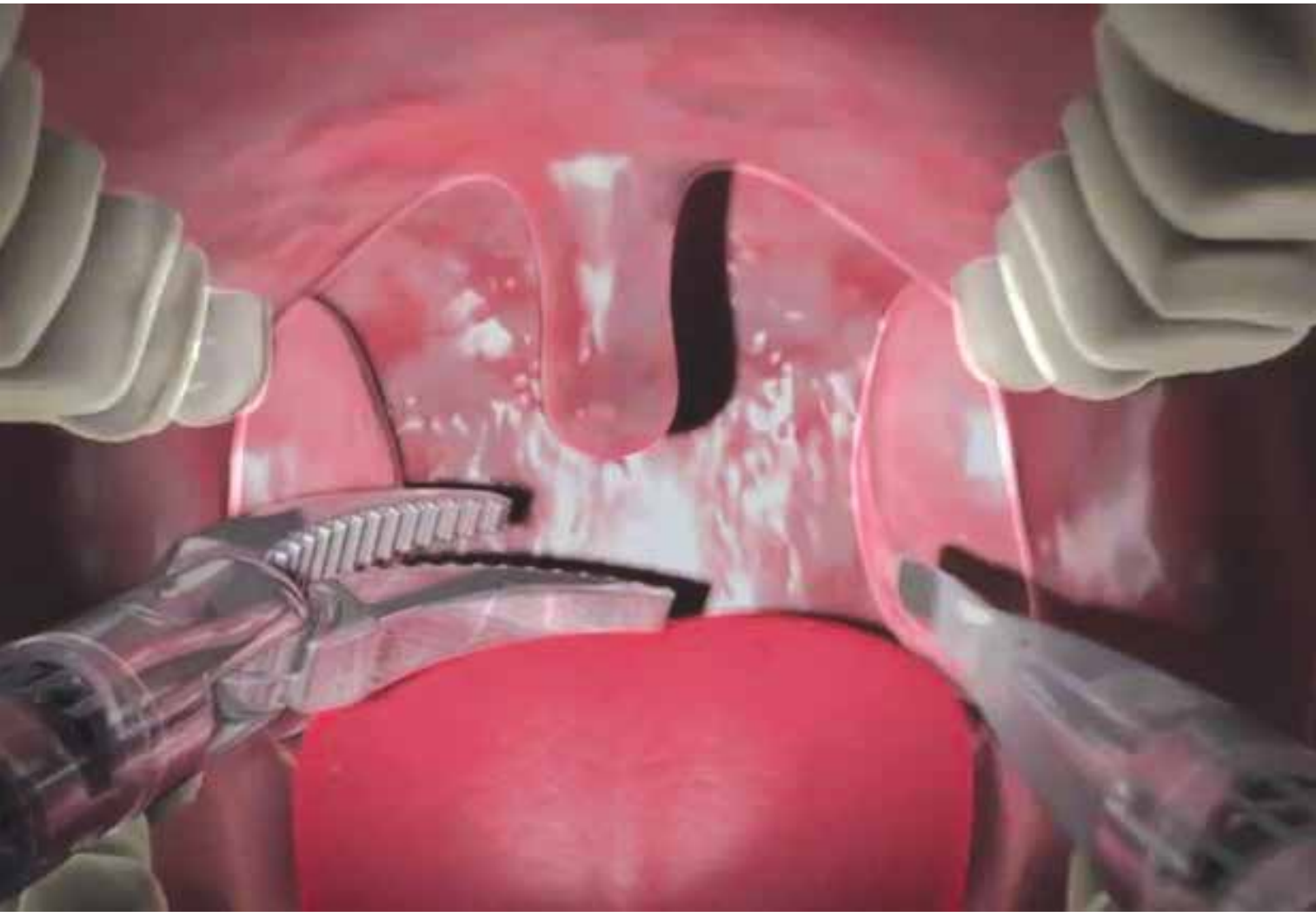
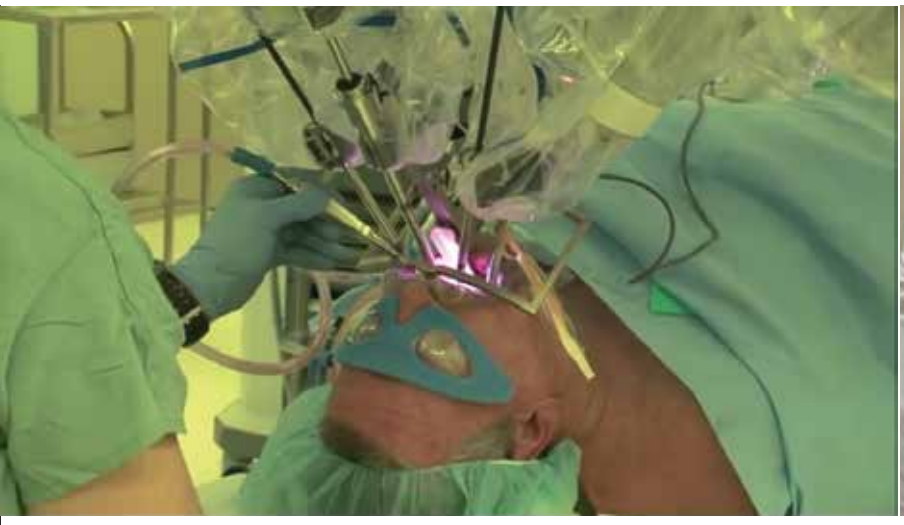


Researcher develops **Robotic Surgery Technique** to Treat Previously Inoperable **Head and Neck Cancer**

In a groundbreaking new study, UCLA researchers have advanced a robotic surgical technique to successfully access a previously unreachable area of the head and neck.

This pioneering method can now be used safely and efficiently in patients to remove tumors that many times were previously considered inoperable, or that necessitated the use of highly-invasive surgical techniques in combination with chemotherapy orradiation therapy.

Developed by Dr. Abie Mendelsohn, UCLA Jonsson Comprehensive Cancer Center member and director of head and neck robotic surgery at UCLA, this new approach provides the surgical



community with a leading-edge technology roadmap to treat patients who had little or no hope of living cancer-free lives.

"This is a revolutionary new approach that uses highly advanced technology to reach the deepest areas of the head and neck," said Mendelsohn, lead author of the study. "Patients can now be treated in a manner equivalent to that of a straightforward dental procedure and go back to leading normal, healthy lives in a matter of days with few or even no side effects."

The parapharyngeal space is pyramid-shaped area that lies near the base of the human skull and connects several deep compartments of the head and neck. It is lined with many large blood vessels, nerves and complex facial muscles, making access to the space via traditional surgical options often impossible or highly invasive.

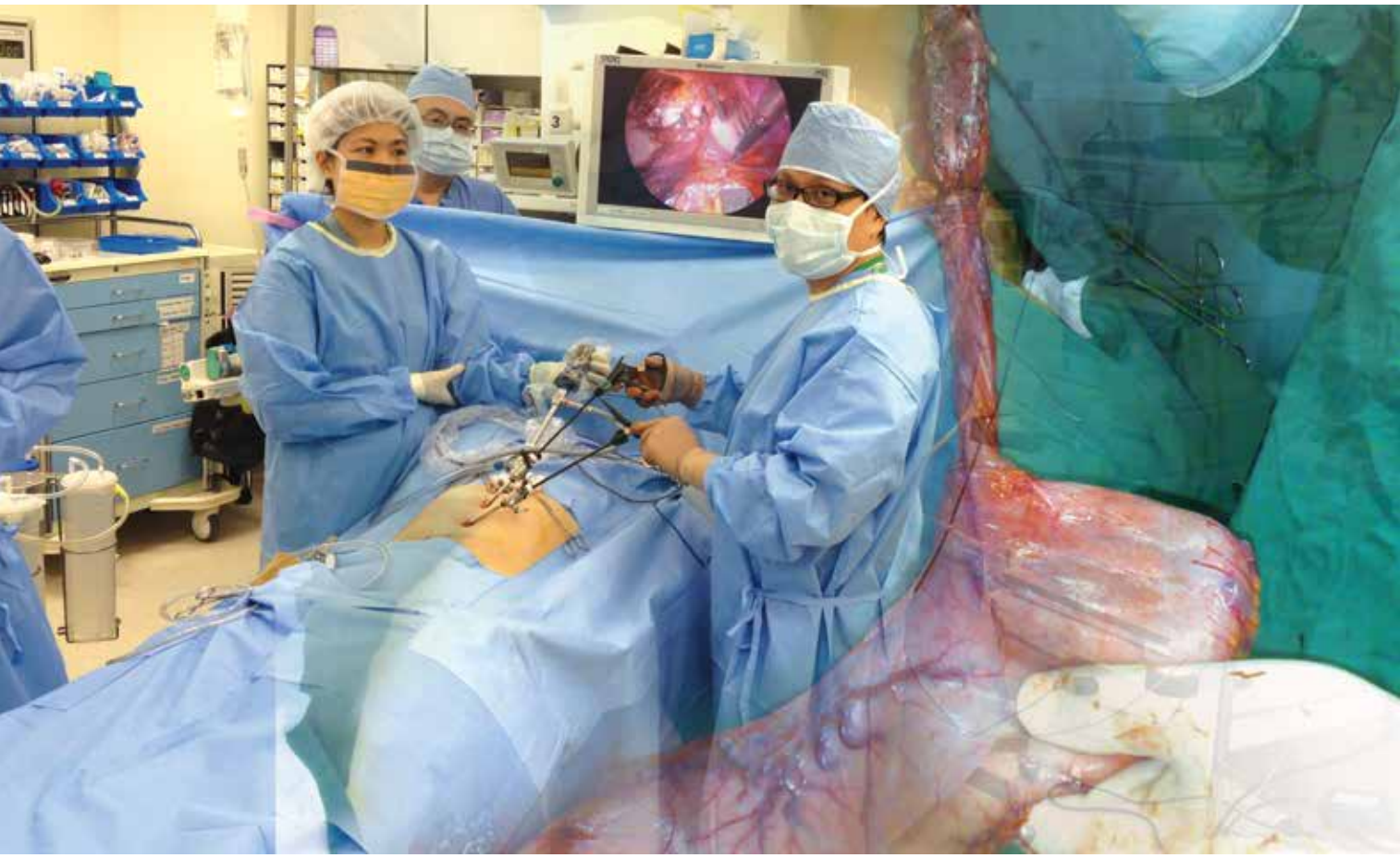
Current surgical techniques can necessitate external incisions be made to the patient's neck, or the splitting of their jaw bone or areas close to the voice box. Chemotherapy and radiation therapy are also often required, further complicating recovery and potentially putting patients at risk for serious (or even lethal) side effects.

Approved by the U.S. Food and Drug Administration in 2009, Trans Oral Robotic Surgery (or TORS) utilizes the Da Vinci robotic surgical system, the state-of-the-art technology that was developed at UCLA by the specialized surgical program for the head and neck. TORS uses a minimally invasive procedure in which a surgical robot, under the full control of a specially trained physician, operates with a three-dimensional, high-definition video camera and robotic arms.

These miniature "arms" can navigate through the small, tight and delicate areas of a person's mouth without the need for external incisions. A retraction system allows the surgeon to see the entire surgical area at once. While working at an operating console just steps away from the patient's bed, every movement of the surgeon's wrists and fingers are transformed into movements of the surgical instruments.

Over the course of the robotic program's development, Mendelsohn refined, adapted and advanced the TORS techniques to allow surgical instruments and the 3-D imaging tools to at last reach and operate safely within the parapharyngeal space and other recessed areas of the head and neck.

Currently, Mendelsohn's new procedure largely benefits patients with tumors located in the throat near the tonsils and tongue, but it continues to be adapted and expanded in scope and impact.



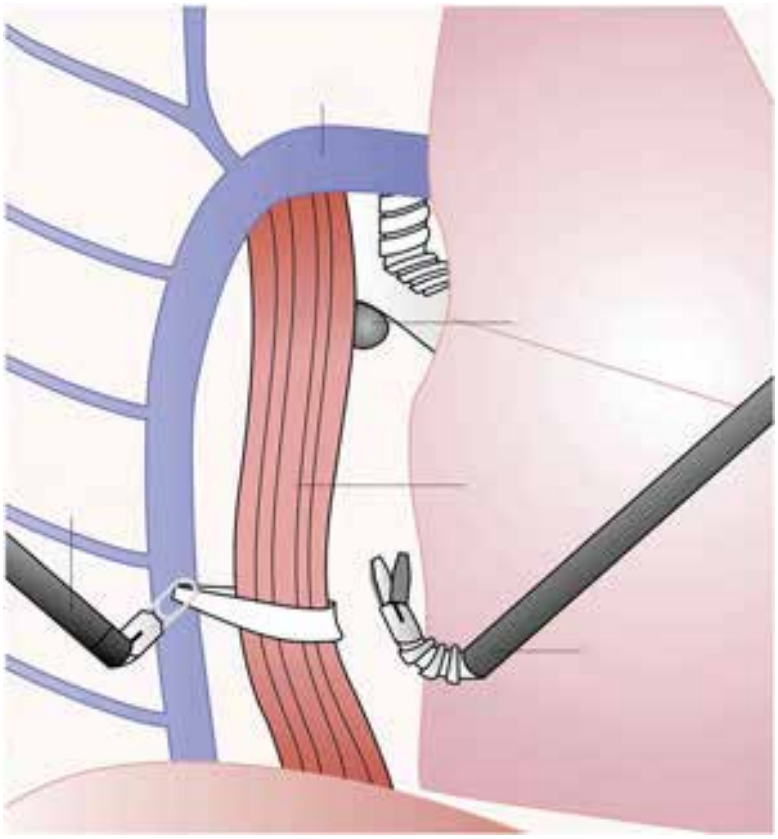
Minimally Invasive Esophagectomy Improves Outcomes

But Remains Underutilized

Surgery remains the most effective curative treatment for esophageal cancer. Yet, many eligible patients do not undergo esophagectomy. An analysis of the NCI's SEER database found that Black and Hispanic patients were significantly less likely to undergo surgery for esophageal cancer compared with whites and that this difference was the underlying cause of disparate survival for esophageal cancer.[1]

Unlike other solid tumors like breast or colon cancer, fewer than half of patients with local or regional disease undergo esophagectomy. Even when surgery is recommended, a significant percentage of patients with esophageal cancer do not undergo surgery.

Patients may be less likely to undergo esophagectomy for a variety of reasons. European studies have found limited benefit for surgery following chemoradiotherapy for esophageal squamous cell carcinoma.2,3 Compared with other solid tumors,



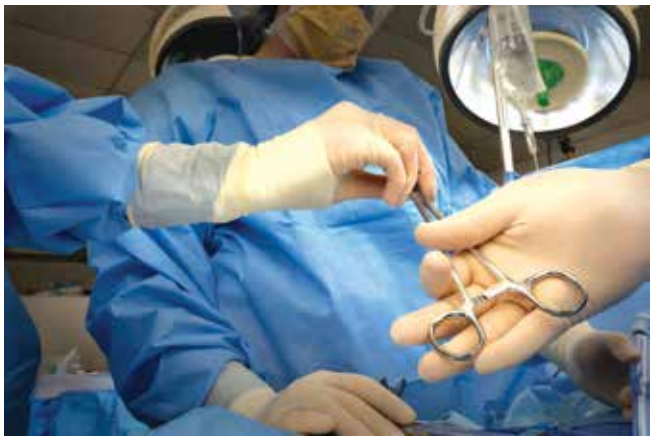
esophagectomy has historically had - relatively high morbidity and mortality rates. Even when there are no complications, the procedure has a major impact on quality of life. However, recent advances in surgical care, particularly the advent of minimally invasive esophagectomy (MIE) may ameliorate many of these concerns, potentially allowing more patients to receive curative therapy.

Some European studies, primarily involving squamous cell carcinoma, have failed to demonstrate a survival advantage for esophagectomy after chemoradiation.

However, these results should be interpreted with caution and surgery remains the standard of care for most resectable esophageal cancer in the United States. The pathologic complete response rate is much lower for adenocarcinoma, which is the predominant histology of esophageal cancer in the United States. The other main criticism of these studies is the relatively high rate of perioperative mortality, potentially negating the benefits of surgery. Multiple studies have demonstrated improved mortality rates for esophagectomy at high-volume centers. Yet, the majority of esophagectomies in the United States are still performed at low-volume centers. Over the last decade, though, there has been a shift of cases to higher volume centers and an overall decrease in mortality from 8% to 4%.4 This has corresponded with a modest increase in the total number of esophagectomies performed annually.

Beyond volume outcomes, a growing body of literature has found reduced complication rates with minimally invasive esophagectomy compared with open. In the first randomized controlled trial of open versus minimally invasive esophagectomy, the MIE group had one-third the rate of pulmonary complication that the open group had.5 Short-term quality of life was better in the MIE group, as well. Mortality rates were below 4% in both groups. More importantly, MIE does not compromise oncologic outcomes.

Comparisons of long-term survival seem to show no statistically significant difference in overall survival or recurrence rates between open and minimally invasive esophagectomy, which is similar to the experience in other solid tumors.6 In terms of long-term quality of life, results from a study of more than 400 patients after esophagectomy recently presented at the World Congress of the International Society for Diseases of the Esophagus found significant benefits in health-related quality of life persisted even 2 years after surgery for patients undergoing MIE compared to thoracotomy.7 At 24 months, pain scores of patients in the MIE group had returned to baseline, but remained elevated in the open group.



Surgical Treatment of Haemorrhoids

Abstract

Hemorrhoids are common human afflictions known since the dawn of history. Surgical management of this condition has made tremendous progress from complex ligation and excision procedures in the past to simpler techniques that allow the patient to return to normal life within a short period. Newer techniques try to improve on the post-operative complications of older ones. The surgical options for the management of hemorrhoids today are many. Capturing all in a single article may be difficult if not impossible. The aim of this study therefore is to present in a concise form some of the common surgical options in current literature, highlighting some important post operative complications. Current literature is searched using MEDLINE, EMBASE and the Cochrane library. The conclusion is that even though there are many surgical options in the management of hemorrhoids today, most employ the ligature and excision technique with newer ones having reduced post operative pain and bleeding.

Hemorrhoids are common clinical conditions. About half of the population has hemorrhoids by the age of 50 years. It is estimated that 58% of people aged over 40 years have the disease in the USA.[1] Almost one third of these patients present to surgeons for treatment.[1] Hemorrhoids can occur at any age, and they affect both men and women. Exact incidence in developing countries is unknown, but the disease is being more frequently encountered, perhaps due to westernized life style. Report of first recorded treatment for hemorrhoids comes from the Egyptian papyrus dated 1700 BC: "… Thou shouldest give a recipe, an ointment of great protection; Acacia leaves, ground, titurated and cooked together. Smear a strip of fine linen there -with and place in the anus, that he recovers immediately.[2]

Hippocrates in 460 BC wrote of hemorrhoids treatment similar to today's rubber band ligation procedure thus: "And hemorrhoids in like manner you may treat by transfixing them with a needle and tying them with very thick and woolen thread, for application, and do not forment until they drop off, and always leave one behind; and when the patient recovers, let him be put on a course of Hellebore."[2] A Roman physician named Celcus (25 BC - AD 14) described the ligation and excision surgeries, as well as possible complications. Galen (AD 13I - 201) also promoted the use of severing the connection of the arteries to veins in order to reduce pain and avoid spreading gangrene.

The Indian Susruta Samhita, an ancient Sanskrit text dated between the fourth and fifth century AD, described treatment procedures comparable to those in the Hippocratic treatise, but with advancement in surgical procedures and emphasis on wound cleanliness.[2]

By the 13th century, there was great progress in the surgical procedure, led by European Master Surgeons,' notable among whom were Lanfrank, of Milan; and Guy de Chauliac, Henri de Mondeville and John, of Ardene.

During the 19th century, another mode of treatment for hemorrhoids, called anal stretching or rectal bouginage, became popular. In the USA, Mitchell (of Illinois) first used carbolic acid for injecting hemorrhoids, in 1871. In 1888, Fredrick Salmon,

the founder of St. Marks' Hospital, expanded the surgical procedure for hemorrhoids into a combination of excision and ligation, where the peri-anal skin is incised, the hemorrhoidal plexus and the muscles are dissected, and the hemorrhoid is ligated.[2,3] Today's Ferguson and Milligan-Morgan procedures are considered a modification of the Salmon's techniques. The diathermy hemorrhoidectomy by Alexander Williams, rubber band ligation by Barron, and the stapled hemorrhoidectomy by Longo were three additional developments in the late 20th century.

ETIOLOGY

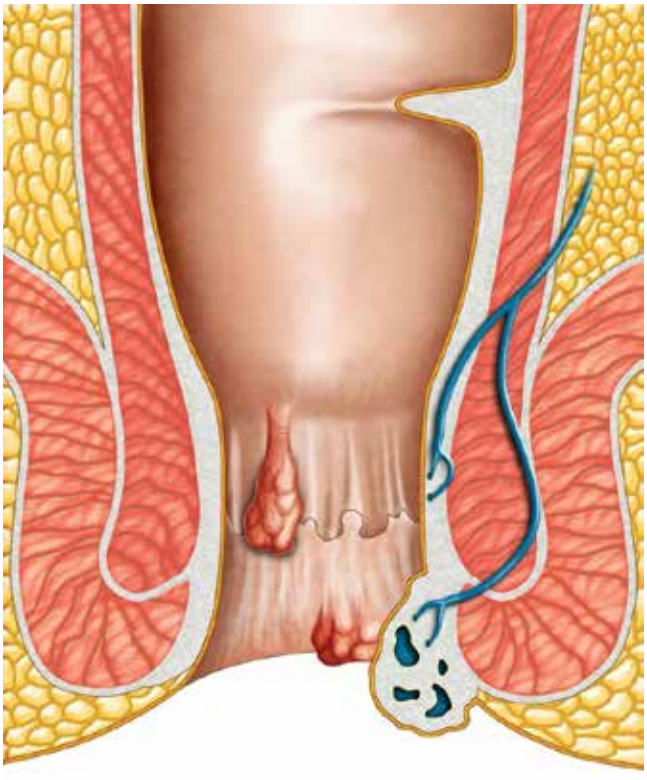
Hemorrhoids are cushion sinusoids thought to function as part of the continence mechanism and aid in complete closure of the anal canal at rest.[4] The main cushions lie at the left lateral, right anterior and right postero-lateral portions of the anal canal. Secondary cushions may be present. Bleeding and thrombosis of the pre-sinusoidal arterioles may occur in association with prolapse. Proposed etiological factors include constipation, prolonged straining, pregnancy, obesity, ageing, hereditary, derangement of the internal anal sphincter, weak blood vessels and absent valves in the portal vein. The erect posture of humans is also a predisposing factor. Despite several studies, the pathogenesis of hemorrhoids still remains unclear.[5]

CLASSIFICATION

Hemorrhoids can either be external or internal. The external variety is covered by skin below the dentate line, while the internal variety lies proximal to the dentate line. Combination of the two varieties constitutes interoexternal hemorrhoids. Internal hemorrhoids are further classified into the following grades:

SYMPTOMS

The main complaints are bleeding during or after defecation, pain, prolapse, itching and peri-anal



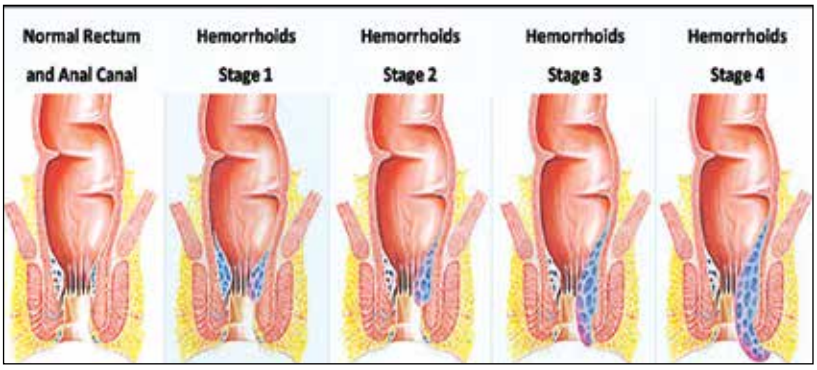
soiling. Diagnosis is made by examining the anus and anal canal, and it is important to exclude more serious causes of bleeding, like rectal cancer.

DIFFERENTIAL DIAGNOSIS

Differential diagnosis of hemorrhoids includes anal skin tags, fibrous anal polyp, peri-anal hematoma, rectal prolapse, anal fissure, dermatitis and rectal tumor.

TREATMENT

Prevention is the best treatment for hemorrhoids. The disease once established tends to get worse over time.[5] Medical application of creams and suppositories can relieve irritation and pain but rarely provide long-term benefit.[5] A high-fiber diet and bulk laxatives prevent constipation and worsening of the disease without achieving a cure. The mainstay of treatment therefore is surgical. But unfortunately, operative hemorrhoidectomy is usually associated with significant postoperative



complications, including pain, bleeding and anal stricture, which can result in protracted period of convalescence.[6] This has therefore stimulated continuing efforts to develop new techniques with less painful course and faster recovery. Recent advances in instrumental technology have led to the development of the bipolar electro-thermal devices - ultrasonic scalpel, circular stapler and the ligasure vessel-sealing systems. It is now possible to vaporize' hemorrhoids, with the advent of the atomizer wand. Some of the surgical options for treating hemorrhoids include the following:

Nonoperative (conservative) options: Rubber band ligation, sclerotherapy, infrared photocoagulation, cryotherapy, manual anal dilatation, LASER hemorrhoidectomy, the harmonic ultrasonic scalpel hemorrhoidectomy, Doppler-guided hemorrhoidal artery ligation, and the new atomizing technique that uses the atomizer wand to excise and vaporize hemorrhoids. Most nonoperative procedures are reserved for first- and second-degree hemorrhoids and are usually carried out on outpatient basis.

Operative options: The clamp and cautery hemorrhoidectomy, open hemorrhoidectomy, closed hemorrhoidectomy, submucosal hemorrhoidectomy, whitehead circumferential hemorrhoidectomy, stapled hemorrhoidectomy, radiofrequency ablation and suture fixation hemorrhoidectomy, pile suture' method, the bipolar diathermy hemorrhoidectomy, and the ligasure hemorrhoidectomy. Operative hemorrhoidectomies are reserved mainly for third- and fourth-degree hemorrhoids.

Nonoperative Procedures

Rubber band ligation

Bleeding from first-, second- and some selected third-degree hemorrhoids can be treated by rubber band ligation. By this method, mucosa 1-2 cm above the dentate line is grasped and pulled into a rubber band applier (the Barron gun). After firing the gun, the rubber strangulates the underlying tissue causing scarring and preventing further bleeding and prolapse. Generally, only one or two quadrants are banded per visit. No anesthesia is required. Results are superior to those of injection sclerotherapy.[6]

A recent meta-analysis of hemorrhoidal treatment concluded that rubber band ligation was the initial mode of therapy for first- to third-degree hemorrhoids.[7]

Injection sclerotherapy (Mitchell technique)

Mitchell (of Illinois, USA) first used carbolic acid for injecting hemorrhoids in 1871.[8] The method offers effective day care treatment for first-, second- and some third-degree hemorrhoids. A quantity of 1-3 mL of a sclerosing agent (5% phenol in almond or Arachis oil, sodium morrhuate or quinine urea) is injected into the submucosa of each hemorrhoid. The objective is to cause thrombosis of the vessels and promote fibrosis, which retracts the prolapse. Where possible, the Gabriel's syringe should be used. It is specially adapted to pass through the proctoscope. Disposable syringes have however now replaced the Gabriel's syringe. Not more than 3 injections at 6-week intervals should be given in one phase of treatment.[8] A course of several injections may be required. Complications are few, though infection and fibrosis have been reported.

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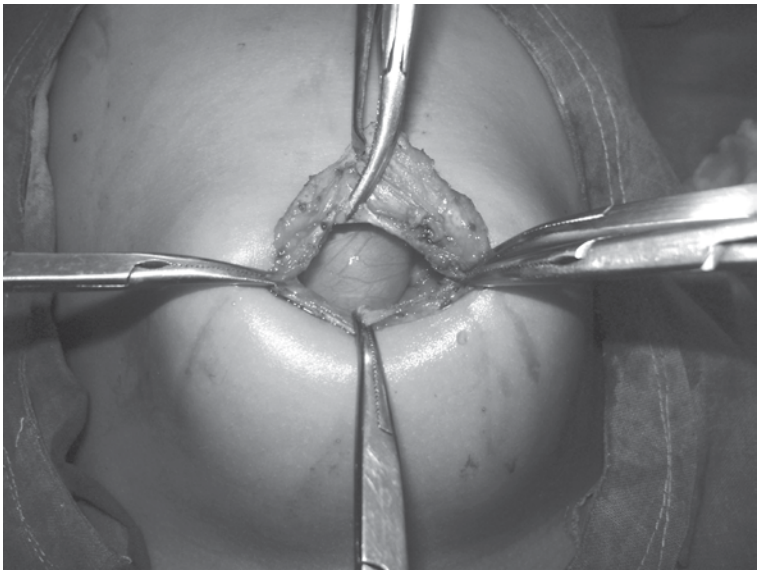
A hernia is a protrusion of an organ through the wall that normally contains it

Most hernias result from a tear in the lining, or fascia, beneath the abdominal muscles, allowing the intestines to protrude. In many cases, this process begins at birth and is an inherited condition. While far more common in men, they are quite frequent in women as well. These hernias affect people of all age groups, from infants to seniors.

The most common types of hernia are inguinal (inner groin), incisional or postoperative (resulting from an incision), femoral (outer groin), umbilical (belly button), and hiatal (upper stomach).



Hernia operations are among the most common procedures performed today.The only way to effectively treat a hernia and provide lasting relief is to have it surgically repaired. Apart from the fact that hernias can cause significant morbidity they can also become life threatening if strangulated.

The most common types of hernia are inguinal (inner groin), incisional or postoperative (resulting from an incision), femoral (outer groin), umbilical (belly button), and hiatal (upper stomach).

Inguinal hernias are by far the most common type of hernia. They develop in the groin area and represent 80% of all external abdominal wall hernias.

Hernias are typically repaired through a surgical procedure called herniorrhaphy, in which the surgeon repairs the hole in the abdominal

wall by sewing surrounding muscle together or by placing "mesh" over the defect.

A mesh technique should be used in young men (18–30 years) irrespective of the type of inguinal hernia. Lightweight material or reduced pore size material (less than 100 μm) mesh should be used. An endoscopic approach is preferred in female herniorrhaphy. Paediatric laparoscopic hernia repair is a good option in selected cases.

During a laparoscopic hernia repair, the surgeon makes very small incisions to pass through specialized instruments and an endoscope, a device that allows the surgeon to see the operative area without opening the patient up. The laparoscopic technique in the treatment of inguinal hernia is associated with less wound infection rates and a faster return to normal activity. Advantages of Laparoscopic hernia repair include less postoperative pain and shorter recovery, visualization of undiagnosed hernias and their repair. Laparoscopy has definitive advantage in repair of bilateral and recurrent hernias.

Incisional hernias present a more heterogeneous problem for the abdominal wall surgeon. They range from small defects of no more than a few centimeters to huge complex hernias with significant loss of domain requiring a multidisciplinary approach with plastic surgeons and specialist anesthetists and intensivists. Open repair has the advantages of reconstituting abdominal wall anatomy and returning physiological function to the abdominal wall. Laparoscopic repair has been proved to be having better results than open surgery especially because of reduced post operative stay and earlier return to work. There is a marked reduction of postoperative wound infection in laparoscopic repair as compared to open surgery. Pain in the immediate postoperative period is same in both approaches but recovery is accelerated in the laparoscopic approach.

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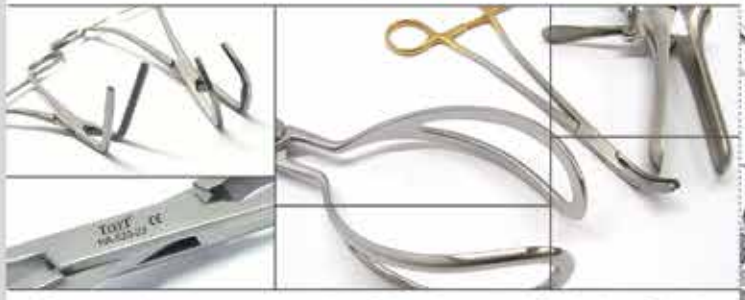

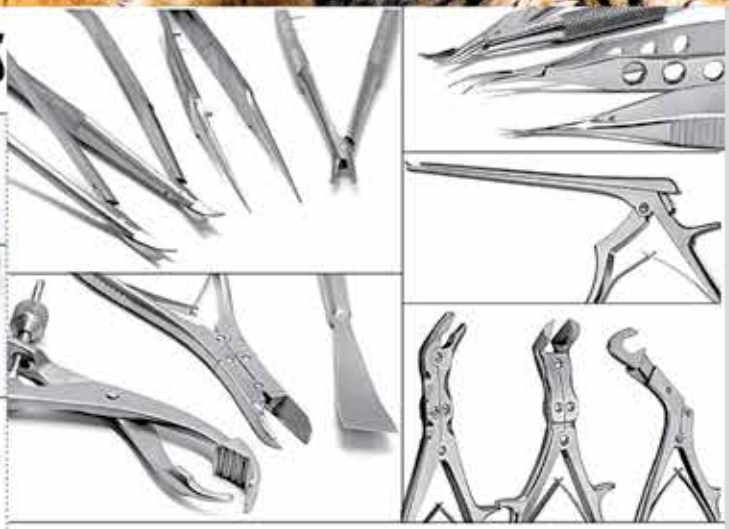

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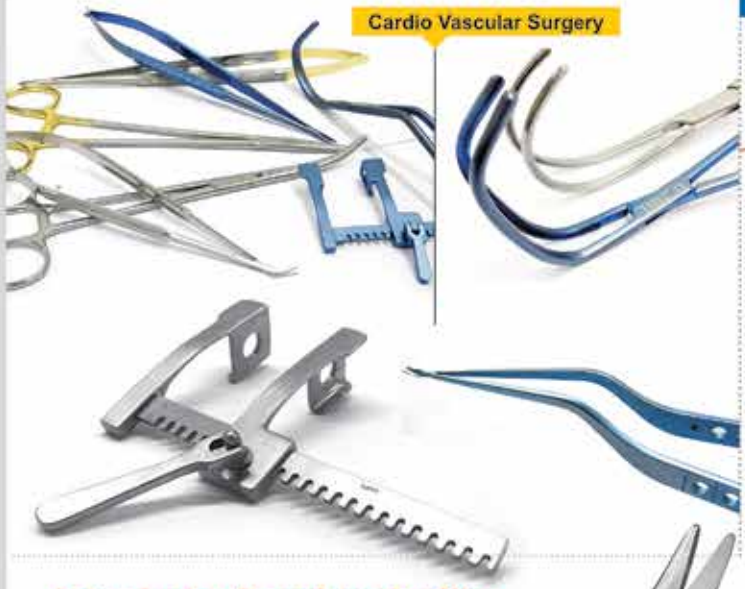

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...*SAVE* critical floor spaces...

...Help *HEAL* faster...&

...Help *REDUCE* Healthcare Delivery *COSTS*

61 Years!

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