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# *Editorial*

## PEDIATRIC LAPAROSCOPY IN BANGLADESH: CURRENT SITUATION AFTER OVER A DECADE OF INTRODUCTION

Laparoscopic surgery owes much of its history to the development of endoscopic technique. Early physicians such as the Arabian, Albukasim (936-1013 A.D.), and later in 1805, the Frankfurt-born physician, Phillip Bozzini, were among the first to develop methods to examine body orifices. Laparoscopy or endoscopically examinining the peritoneal cavity was first attempted in 1901 by George Kelling who called this examining procedure "*Celioscopy*". After a long pause, throughout the 1960's and 1970's, laparoscopy was only part of gynecological practice.[1]

The first publicized laparoscopic cholecystectomy performed on a human patient was done in 1987 by the French physician Philip Mouret and thereafter this has become the standard therapy for routine gallbladder removal. The rapid acceptance of the technique of laparoscopic surgery by the general population is unparalleled in surgical history.[1] Dr Steve Gans, who described in 1971 the use of what he called "*Peritoneoscopy"* in children, considered as pioneer in the field.[2] However, Pediatric laparoscopy expanded in the hands of Keith Georgeson, Whit Holocomb, Steve Rotheberg and other pediatric surgeons across the world starting in the 1990's.

Opponents were always there to denounce this technological advancement. Kurt Semm, a gynecologist had developed the CO2 insufflator and in 1983, he reported on the first laparoscopic appendectomy. His colleagues in his hospital proposed that he undergo a brain scan to see if his erratic and bizarre behavior of wanting to operate through a telescope was because of some organic and potentially remedial problem.[2] Skepticism about the role of laparoscopy in children was also there.[3]

Every major leap forward for our species has come through adoption of innovation. From fire, language to electricity and modern medicine, each innovation has delivered us capabilities beyond our simple biological shell. Innovation is a fundamental characteristic of who we are, but digging deeper we find that every new scientific, technical or social innovation created a tension between the established order, and aspirants. It is natural that a society would want to keep what they think works, the status quo. We are also acutely aware that a technological change alters society in unpredictable ways. It is the uncertainties associated with change - especially the fear of losing what we value - that leads to resistance to change.

Laparoscopy for pediatric population has been introduced in Bangladesh in 2005 by few relatively younger people. Many junior pediatric surgeons took interest and attended the workshops organized mostly by the author and few came to spend considerable time for training. There was no opposition from the senior pediatric surgeons; however there were also not many enthusiasms either. Pioneers of Pediatric surgery in our country were mostly general surgeons converting themselves into pediatric surgeons, probably did not care much about it. The earlier generation of formally trained pediatric surgeons also could not embrace laparoscopy with open arms. Because they were leading the pediatric surgical departments across the country, there relative lack of enthusiasm in effect contributed negatively in the propagation of this technology. Those who could have positive impact moved themselves out of the teaching institutions due partly to the lack of getting desired respect and importance from the system. Apart from few individuals including the author, only two institutions in the country now offer laparoscopy as an option for treating certain diseases in children routinely, Dhaka Medical College and Chattagram Maa O Shishu Hospital Medical College. Unfortunately, two premier teaching institutions pediatric surgery, Bangabandhu Sheikh Mujib Medical University and Dhaka Shishu Hospital seldom provide laparoscopic options for children.

While many medical colleges have the necessary pediatric instruments, the pediatric surgeons may be lacking the proper training and much needed confidence. Now is the time that we ask ourselves the question whether children of Bangladesh deserve to get laparoscopy as a treatment option when indicated. If we think they do, then we must take the initiative to train our colleagues and students.

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**References**

1. Spaner SJ, Warnock GL (1997) A Brief History of Endoscopy, Laparoscopy, and Laparoscopic Surgery. J Laparoendosc Adv Surg Tech; 7 (6): 369-74
2. Georgeson K (2011) Pioneers, cowboys, and desperados: a brief history of pediatric surgical innovation. J Pediatr Surg; 46: 1–7
3. V. Raveenthiran (2010) Pediatric laparoscopy: Facts and factitious claims. J Indian Assoc Pediatr Surg; 15(4): 122–128.