Aust N Z J Obstet Gynaecol 2018; 58: E3–E4

ANZJOG

DOI: 10.1111/ajo.12728

LETTERS TO THE EDITOR

Gastric decompression before laparoscopic entry via Palmer's point

Having received a number of relevant reports, the Queensland Gynaecological Cancer, Quality Assurance Committee (QGC QAC) has asked us to widely disseminate information about the risks of inadvertent gastric perforation with laparoscopic abdominal access in the left upper quadrant.[1]

Palmers point[2] is in the left subcostal para-rectus region[3] and may be the preferred site of entry by Veress needle, Hasson cannulation or direct insertion of the trocar. This is particularly so in patients known or suspected to have periumbilical adhesions or after repeated failure of periumbilical attempts. Gastric decompression by orogastric or nasogastric tube may lessen the risk of gastric perforation with Palmer's point access and is currently required in a Clinical Practice Guideline by the Society of Obstetricians and Gynaecologists of Canada.[4]

This letter is being widely distributed to the anaesthesia and gynaecology communities in Australia in the hope that awareness, communication and cooperation could reduce the risk for iatrogenic gastric injury with Palmer's point access. This includes simultaneous publication, with permission, in the journals *Anaesthesia and Intensive Care* and the *Australian and New Zealand Journal of Obstetrics and Gynaecology*.

Peter D. Cook[1]
Russell P. Land[2]

[1]*Queensland Gynaecological Cancer, Quality Assurance Committee, Brisbane, Queensland, Australia*
[2]*Gynaecologic Oncology, Greenslopes Private Hospital, Brisbane, Queensland, Australia*
Email: cookanaes@bigpond.com

REFERENCES

1. Alkatout I, Mettler L, Naass N *et al.* Abdominal anatomy in the context of port placement and trocars. *J Turk Ger Gynaecol Assoc* 2015; **16**: 241–251.
2. Tufek I, Akpinar K, Sevinc C, Kural AR. Primary left upper quadrant (Palmer's Point) access for laparoscopic radical prostatectomy. *Urol J* 2010; **7**: 152–156.
3. Palmer R. Safety in laparoscopy. *J Reprod Med* 1974; **13**(1): 1–5.
4. Vilos G *et al.* Laparoscopic entry: a review of techniques, technologies, and complications. *SOGC Clinical Practice Guideline JOGC* 2007; **193**: 433–447.

Working hours of obstetrics and gynaecology trainees in Australia and New Zealand

In his book *Outliers; the story of success*, Malcolm Gladwell, historian and non-fiction writer, conferred CM (Canadian Order of Merit), projected the 10 000 Hour Rule.[1] This well-researched idea holds that 10 000 h of deliberate practice is required to become highly proficient in any field. The term 'deliberate practice' means pushing one's skill set to the maximum extreme. Gladwell demonstrates that most living persons revered as being at the top of their fields in professions, music, sports, education, entrepreneurship and games such as chess and bridge, worldwide have fulfilled this apprenticeship.

Although the principle is under challenge, the broad tenet does explain why any one person can only properly master one, or at best a few related activities in their lifetime. With this in mind I was bemused by the recent articles in the October issue of *ANZJOG* dealing with the working hours of trainees in obstetrics and gynaecology[2,3] where a 53.1 h working week was projected as dangerous for both patients and doctors.

My own training commenced at the very same King Edward Memorial Hospital during 1971–1973 where the obstetric and gynaecological case load was similar to today; but I was one of only three Registrars (supported by two Senior Registrars); however, I understand the Registrar numbers now total 52 doctors!

Despite a continuous working week of more than 80 h, and many over 100 h, I never experienced fatigue to the extent of 'dozing while driving'. I was devoted to the work and even had a notice in the labour ward to call me on non-rostered days if anything 'interesting' presented. In this way I was able to experience cases of symphysiotomy, replacement of an inverted uterus (two occasions), cleidotomy to effect vaginal delivery of large anencephalic infants, amniotic fluid embolism, massive intrapartum haemorrhages, the rapid placement of subclavian central venous pressure lines in collapsed women and assisting with laparoscopic surgical complications which were relatively common in those introductory days. Many of these cases are documented in my Member Royal College of Obstetrics and Gynaecology (MRCOG)[4] commentaries.

© 2018 The Royal Australian and New Zealand College of Obstetricians and Gynaecologists

When I pursued four further years advanced training at the Royal Free Hospital in London from 1976, I am aware the British consultants were amazed at the workload I, and other Australian colleagues, could manage. Again, the roster was one in three. During those years I was introduced to microsurgery, laser applications and ultrasound for both obstetrics and gynaecology as well as the emergent field of in vitro fertilisation which provided the data for my MD thesis. By the time I returned to Perth in 1980, the competency level enabled confident entry into new areas, including laparoscopic hysterectomy, laparoscopic myomectomy and extensive excision of invasive endometriosis, including Cullen's disease where fertility was to be preserved.

While I also enjoyed social pursuits and became reasonably competent at windsurfing, tri-athlete sports and several styles of dancing, these only reached a middle-order ranking as explained by Gladwell. Personally, I found my entire career in obstetrics and gynaecology, progressing into reproductive medicine including andrology, to be a situation of excitement and self-actualisation. No fatigue, no dozing and no regrets; still doing around 50 h per week at age 72 years. I cannot support the ideas projected by the four authors.[2,3]

John L. Yovich[1,2,3,4]
[1]*PIVET Medical Centre, Perth, Western Australia, Australia*
[2]*Cairns Fertility Centre, Cairns, Queensland, Australia*
[3]*PIVET Fertility Darwin, Darwin, Northern Territory, Australia*
[4]*Curtin University, Perth, Western Australia, Australia*
Email: jlyovich@pivet.com.au

DOI: 10.1111/ajo.12779

REFERENCES

1. Gladwell M. *Outliers; the story of success Little, Brown and Company*. New York, Boston, London: Hatchette Book Group, 2008. HC ISBN 978-0-316-01792-3. International edition ISBN 978-0-316-03669-6. Pp309
2. Tucker PE, Cohen PA, Bulsara MK, Acton J. Fatigue and training of obstetrics and gynaecology trainees in Australia and New Zealand. *Aust N Z J Obstet Gynaecol* 2017; **57**: 502–507.
3. Acton J, Tucker PE, Bulsara MK, Cohen PA. Working hours of obstetrics and gynaecology trainees in Australia and New Zealand. *Aust N Z J Obstet Gynaecol* 2017; **57**: 508–513.
4. Yovich JL. Obstetric and Gynaecological Case Records & Commentaries for MRCOG examination 1976. Copy accessible online at Research Gate