

Formation of a Double Primary Tumour Registry in Malaysia with One Tumour Gynaecological in Origin

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ABSTRACT

Objective: Foundation with a new special set-up to form a double primary tumour registry in Malaysia was started especially wherein one tumour is gynaecological in origin. The author has personally treated persons with such ailments in at least 12 to 16 occasions (when the gynaecological malignancy occurred, or the next separate discrete tumour event occurred synchronously or metachronously where appropriate referral was made). **Methodology:** Synchronous and metachronous double primary tumours occurring in any one patient in Malaysia should be formally entered with consent into a special new registry in Malaysia. This will enable the collection of data with possible further studies and research of this not uncommon phenomenon not necessary but including tumour tissue/chromosomal studies/others. **Results:** Better collection of data, tumour tissue, chromosomal studies, family linkage studies, epidemiology studies, family screening (where needed) can be enabled. **Conclusion:** Better data accrual will lead to better understanding and knowledge of this predicament which is uncommon but does occur in variance but not in absentia. New syndromes and tumour genetics are waiting to be discovered leading to greater purity of science with better care and better results.

Designing Specific Gynaecological Laparoscopic Equipment for Female Patients with High Body Mass Index (BMI) (Obese) and Thick Abdominal Aprons

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ABSTRACT

Objective: To point out on the need for a different range of gynaecological laparoscopic equipment that are specifically designed for women with high BMI and thick abdominal aprons. **Methodology:** There are few specific and specially designed gynaecological laparoscopic equipment like entry trocars or instruments that are specifically designed for female patients with high BMI. The current standard trocars are too short to allow entry and subsequently working through longer depths of fat tissue. Standard trocars might "peek" out beyond intra-peritoneally the fat layer by clearances of 1 to 3mm. only or none. Entry forces are also different between obese and non-obese patients due to the depth/resistance of fat tissue and overall required travel – length of laparoscopic trocars. Entry trocars will face 1) higher needed entry force and 2) possible deflection of entry trajectories that require 3) traversing through more fat. This can possibly be a potential source of complications. As more force is required trocar heads need to be more robust, aerodynamic and sleeker in design with possibly thicker build to withstand more forces. Anaesthetic complications of pneumoperitoneum and Trendelenburg position are other issues. **Results:** Utilising standard equipment for female patients with high BMI places many restrictions and risks in gynaelaparoscopic surgery. The distance between outer skin and peritoneum is increased. **Conclusion:** Operating laparoscopically in women with high BMI and thick abdominal aprons requires specifically designed and longer trocars in order to reduce entry forces and equipment enforced errors if standard equipment are used.