Invited Commentary

Reading this well constructed review, one tends to nostalgically recollect the struggle to develop reconstructive vascular surgery in this country. As a tribute to those pioneering spirits I would like to place on record the evolution of vascular surgery in Sri Lanka.

In the 1950's when reconstructive vascular surgery began to salvage ischaemic limbs elsewhere in the world, the dominant cause of critical limb ischaemia in Sri Lanka (Ceylon) was an arteritis affecting the young [1]. Dr P.R. Walpita [2], trained in the skills of reconstruction, gave up due to poor results and went on to pioneer paediatric surgery in this country. Dr. H. L. Eaton of the university surgical unit at Peradeniya made forays into reconstruction with mixed results [3]. In the late 1960's, one saw a few successful fem – pop bypass grafts done by Dr. Noel Bartholomeusz and the surgeons of the "Hope Ship"; Dr. Kradijan [4] in particular.

It was Prof. A.H.S. Sheriffdeen of the university surgical unit in Colombo, in the early 1970's having trained at St. Mary's London under Eastcott and others, who should be credited with the development of reconstructive arterial surgery in this country. His unit not only performed with success emergency and routine vascular procedures but trained many young surgeons to do so.

The university surgical unit at Peradeniya followed in the mid 1970's and maintained an audit which helped to unravel the complex patterns of presentation in Sri Lanka [5].

Together, these two vascular units in Colombo and Kandy provided the vascular service cover for much of the country over the next three decades. The vascular injuries sustained during the thirty year civil war between the North and South of this country provided a turnover for the trainees to acquire an in-depth experience. Since the millenium, with the establishment of other vascular units manned by Ministry of Health consultants in Colombo and Kandy, the specialty gained more strength but much yet needs to be done especially in making available vascular services in other provinces of this country.

The ageing population and the changes in lifestyles that have followed the improving living standards in Sri Lanka have caused an increase in the prevalence of non communicable diseases, often reflecting those seen in the west. The prevalence of Thromboangiitis Obliterans is seen to be regressing and we see a dramatic increase in the prevalence of atherosclerotic disease.

In Sri Lanka, seventy five percent of patients with chronic obliterative arterial disease presenting to hospital have critical ischaemia affecting their lower limbs, quite in contrast to the west. This seems to be due to a combination of a more florid type of atherosclerosis causing combined segment disease even in the non diabetic and thromboangiitis obliterans [5].

The high prevalence of critical ischemia with sepsis pose problems to the vascular surgeon in this country when prosthetic grafts need to be used. Groin nodal cult ures obtained by fine needle aspiration [6], access of the femoral artery from a more lateral incision [7] and the use of bipolar diathermy to coagulate any accidentally interrupted lymphatics during dissection, together with intravenous high doses of the appropriate antibiotics have all proved useful to restrict prosthetic graft sepsis.

The units in Colombo and Kandy are helped by our interventional radiology colleagues who provide balloon dilatation and stenting in collaboration with us. Though they provide this service, the high cost of single use guide wires (around Rs. 35,000) and stents (Rs.90,000), have applied some considerable restrictions on the free use of this service. It seems strange that these very same items are much less expensive in India and even less in USA. If only we could purchase direct from the manufacturer it will certainly cut costs and hence improve the service. The routine use of stents in those with critical ischaemia and sepsis may require forethought and selectivity.

Endovascular prostheses for aortic aneurysms, also highlighted in this article, have

now mostly overcome the initial problems such as endoleaks. But for the prohibitive cost, they would be a boon to those with co-morbidities that make open surgery unsafe. The hand skills and the experience to provide this service is slowly entering the country through newly trained surgeons, returning from vascular centres abroad. Hopefully the private sector would offer them an opportunity to retain their hand skills and keep alive these exciting new developments.

References

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