

NORTH–SOUTH SURGICAL TRAINING PARTNERSHIPS

I would like to congratulate Greive-Price, et al. for their recently published excellent systematic review of North–South surgical training partnerships.¹ This review should be read by anyone considering establishing or evaluating such a program.

There was an inadvertent omission that I would like to address. In the discussion, the authors cited recent editorials articulating a framework for training partnerships.^{2–4} In fact, the citations are all a response to the index editorial that first raised the issue of such frameworks in pediatric surgery.⁵ In that editorial, my co-authors and I confronted the concerns that have stood in the way of enacting effective educational North–South partnerships in our field, presented a model of a successful bidirectional pediatric surgery partnership, and offered mechanisms to avoid surgical adventurism and colonialism.⁶ After several years of discussion and debate instigated by our article, we understand that the American Board of Surgery and the Accreditation Committee for Graduate Medical Education may soon reverse their position and allow such partnerships to take place.

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AUTHOR RESPONSE TO "NORTH–SOUTH SURGICAL TRAINING PARTNERSHIPS"

The authors thank Dr. Emil for the kind words and for highlighting the connections between our cited references, which further contextualizes our findings. We are pleased to hear about the possible developments from the American Board of Surgery and the Accreditation Committee for Graduate Medical Education in allowing bidirectional exchanges in surgical education.

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MORE NOTABLE DEVELOPMENTS FROM THE DEPARTMENT OF SURGERY OF THE UNIVERSITY OF MONTREAL

I read with interest the paper entitled "The Department of Surgery of the Université de Montréal, 70th anniversary," and found omissions of key developments during those 70 years.¹

The first in situ vascular grafts were done by Dr. Paul Cartier of Montreal in 1959.² McPhail reviewed the history of vascular surgery in Canada in 1995.³ It mentioned the origins of the in situ vein bypass in Montreal, Canada, and in London, England, followed by progression of the original techniques in Europe and the United States. However in 1969, there was criticism of the procedure in the United States, but with the perseverance of Dr. Cartier in Montreal and Dr. Hall in Norway, there was a revival of interest in the technique by Leather and Karmody in Albany, New York.³ Dr. Paul Cartier was made officer of the Ordre National du Québec in 2000, not only for the in situ bypass achievements, but also for the world's first femoro-femoral bypass in 1959, axillo-femoral bypass, and carotid endarterectomy without shunt in 1962, at the Hotel-Dieu de Montreal.

Let's not forget the development of minimally invasive surgery of the pituitary gland. During a period when transsphenoidal surgery was on the edge of disappearance, 3 crucial surgeons, Drs. Norman Dott, Gerard Guiot and Jules Hardy, revived the operation, each succeeding at further perfecting the procedure.⁴ Dr. Jules Hardy, a fellow of Guiot, from Montreal, revolutionized transsphenoidal microsurgery with the introduction of the binocular microscope and selective adenomectomy. The principles of

these pioneers have endured and are now extensively employed by neurosurgeons worldwide.^{4,5} Dr. Hardy was made officer of the Order of Canada in 1987, and chevalier of the Ordre National du Québec in 1989.

The contribution of the department in the advancement of breast cancer surgeries and treatments is undeniable, making them less mutilating and increasing survival with numerous publications and participation in National Surgical Adjuvant Breast and Bowel Project (NSABP) randomized controlled trials. Under the mentorship of Dr. Bernard Fisher, Dr. Andre Robidoux became the Director of the Clinical Research Group for breast cancer at Hotel-Dieu and brought NSABP-sponsored trials to more than 5000 breast cancer patients in Montreal. This was supported by 1 of 3 awarded National Cancer Institute treatment and prevention grants for 27 years. In 2010, Dr. Robidoux was a recipient of the Distinguished Investigator Lifetime Achievement Award in recognition of his extraordinary commitment to the NSABP and oncology research. He served as an elected member of the NSABP Foundation board of directors for many years.

Laparoscopic surgery in the early 1990s led to extraordinary developments at the Hotel-Dieu de Montreal, an hospital affiliated with the Université de Montréal. Adrenal surgery changed course with the first report of laparoscopic adrenalectomy (using the lateral decubitus approach) for Cushing syndrome and pheochromocytoma in the *New England Journal of Medicine* in 1992.⁶ This new laparoscopic position also led to facilitating laparoscopic splenectomy in the lateral decubitus, first performed at Hotel-Dieu and now practised worldwide. The first laparoscopic distal and proximal pancreatectomies were also performed in 1992 and 1993, and the first report of laparoscopic liver resection was in 1991.^{7,8} Also the developmental research of endoscopic thyroidectomy using a porcine model at

the Research institute of the Hotel Dieu de Montreal led to the first world endoscopic neck surgery the following year at the Cleveland Clinic, and the first endoscopic parathyroidectomy in Canada a few years later, also at the Hotel Dieu de Montreal.⁹

I have mentioned only a few surgeons and techniques, and I am sure the list can be elongated.

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THE UNEXPLORED ROLE OF METOCLOPRAMIDE: A NON-OPIATE ANALGESIC FOR ACUTE PAIN MANAGEMENT

Rozario presents the surgical dilemma of use and abuse of opioids in pain management in surgical patients.¹ Besides the integrated systems approach detailed by Rozario, I offer my experience with metoclopramide (MTCL) as a useful non-opiate agent for managing acute severe pain, surgical or nonsurgical.²⁻⁴ While consensus statements and guidelines have proven insufficient to overcome opioid abuse, the definitive pharmacologic basis of the analgesic action of MTCL is a welcome addition, but one that is largely ignored. I have used MTCL 20 mg as slow IV bolus (over 2 minutes) and up to 60 mg in GNS 500 mL drip for severe headache, refractory migraine, and nonspecific abdominal pain as an early management strategy with good results (unpublished observations). Care should be exercised in administering MTCL. I always administer MTCL bolus myself rather asking nurses/nursing attendees to do so. Mild sedation, diarrhea and reversible extrapyramidal reactions can occur without long-term or cumulative adverse effects.

Besides its routine antiemetic effect, MTCL releases vasopressin, which in conjunction with serotonin and noradrenaline, forms a powerful adaptive nexus with brain neuronal antinociceptive, vasomotor, and behavioural functions,⁵⁻⁷ all of which are useful in the postoperative state.

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