

So you want to be ... a hepatopancreatobiliary surgeon

Introduction

HPB or hepatopancreatobiliary surgery means looking after patients with 'surgical' diseases of the liver, pancreas, gall bladder and biliary tree. By extension, HPB surgeons also operate frequently on the spleen, stomach, duodenum and jejunum; for example, we are well accustomed to creating a defunctioned (Roux) loop of bowel to act as a conduit or bypass in pancreatobiliary surgery. For the most part the day is spent in theatre dealing with stones, cysts and tumours, but there are other difficult conditions to manage such as portal hypertension and pancreatitis, both acute and chronic.

Within the subspecialty some surgeons concentrate on liver transplants, some on the new endoscopic procedures and a few (like myself) on the pancreas. I say subspecialty because HPB surgery is a component of the specialty of general surgery. Some surgeons do oesophagogastric surgery as well as HPB, and many of us are regularly on call for general surgical emergencies.

I knew that I wanted to be a surgeon from very early days – even before I could spell hepatopancreatobiliary – but not what species of surgeon. Most small boys grow out of the wish to do the same as their father, but mine was a case of arrested development. I stumbled on pancreatic surgery by chance, however.

When I was a registrar in the early 1970s before the advent of ERCP (endoscopic retrograde cholangiopancreatography), the consultant went on leave to Africa. It fell to me to explore a jaundiced patient who was thought to have gall-stones. I was taken aback to discover a carcinoma of the ampulla and appealed for help from the consultant operating next door. As he was embroiled in a lengthy list, he produced a textbook of operative surgery and gave advice thereafter by remote control with the occasional visit to inspect progress.

Professor Robin Williamson is Consultant Surgeon at the Hammersmith Hospital, London W12 0HS

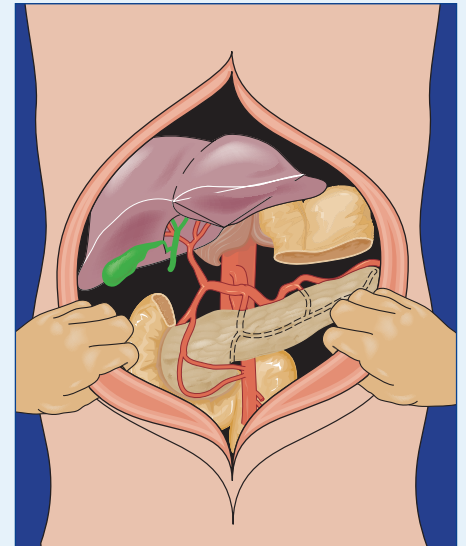
I found myself looking at the portal vein for the first time – its wall can be thin enough for you to see the blood rushing past en route to the liver. The patient survived. I aged, but I also developed a progressive interest in this fascinating organ, the pancreas. Of course, modern training programmes make such a baptism of fire exceptional, yet even as an established consultant one can still find oneself in uncharted seas.

Useful qualities

One valuable criterion for the budding HPB surgeon is stamina. I do not simply mean surviving the long period of surgical training. Operations on the liver and pancreas can take several hours, and the trickiest part – anastomosing small ducts – comes towards the end when you are beginning to wilt. You have to change gear between the destructive and reconstructive phases of the operation.

Another useful quality is a sense of optimism, since the common types of pancreatic and bile duct cancer are difficult to cure. For the patient pancreatic surgery involves relatively high risk for relatively small gain, yet the potential gain is well worthwhile and encourages the surgeon to persist. An interest in pathophysiology is a bonus.

There are so many unanswered questions: why do the liver and small bowel regenerate like a lizard's tail (after partial resection) when the pancreas and spleen do not? Why are most small bowel tumours clustered in the first 25 cm (the duodenum)? The variety of surgical tech-



niques adds spice to an HPB surgeon's life. Laparoscopic surgery came of age with cholecystectomy, yet there is still plenty of scope for the traditional type of open operation. Do not be put off by concerns about technical dexterity: most people can acquire the necessary operative skills with time and proper training.

The future

I believe that the future of HPB surgery is bright. At last we have drugs with proven efficacy against certain HPB cancers, yet surgical removal of the tumour retains a pre-eminent role. There is a realistic prospect of increasing the number of more advanced cancers suitable for resection by downstaging (neo-adjuvant) chemotherapy. One promise that I can make to a prospective HPB surgeon: you will never be bored, and your chosen career will offer endless challenges, both intellectual and manual. Who knows: perhaps surgeons will regularly cure type 1 diabetes in the foreseeable future. **BJHM**

Conflict of interest: none.

KEY POINTS

- Hepatopancreatobiliary (HPB) surgery embraces the liver, pancreas, biliary tree and adjacent organs.
- Diseases to be treated include liver tumours (mostly metastatic), pancreatic and periampullary cancer, gall-stones, pancreatitis and liver failure.
- Although laparoscopic techniques have made enormous inroads into HPB surgical practice, there remains a major role for complex open operations on the liver and pancreas.
- In the field of cancer, powerful new chemotherapy drugs seem likely to increase, not replace, the indications for surgical resection.