

## **Fifth Recipient of the International Observership in Hepato-Biliary-Pancreatic Surgery**

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I spent 18 months, from October 2003 to May 2005, at three institutions in the U.S., namely, Virginia Mason Medical Center (Seattle, WA), Mayo Clinic (Rochester, MN), and UCLA Medical Center (Los Angeles, CA) as the fifth recipient of the JHBPS International Observership. First all of, I would like to thank Dr. Tadahiro Takada as well as other doctors, especially members of the Society's International Exchange Committee, for giving me such a precious opportunity.

The main feature of the program is clinical training and clinical research under a host doctor at each of the three institutions, because one cannot practice medicine without U.S. board certification. I had a great opportunity to observe a lot of surgeries and outpatient clinics, and I also attended conferences where I learned a lot from great discussions. As for research, I was able to access the databases at each institution for my clinical research, and I learned how to put my thoughts and ideas together, giving presentations to others. I was given opportunities to present my study findings at international conferences, and I was advised to submit papers to academic journals.

### **1. Virginia Mason Medical Center, Seattle, WA**

Virginia Mason Medical Center is a private hospital and the third largest hospital in Seattle. It is not a big hospital, but it is a referral center, so doctors there have many cases. At the same time, it is a resident training center. My host there was Dr. L. William Traverso, a world famous pancreatic surgeon. When I arrived there, I had only 7 years of medical practice (with a year and a half doing basic research), so I asked Dr. Traverso to treat me like a resident, since I did not have much knowledge and/or experience. The training in Seattle was very challenging, but my time there was quite fruitful. Even after I finished my training in Seattle, Dr. Traverso made sure that I was doing all right wherever I was throughout the program. It is not too much to say that I could not have completed my study in the U.S. without his assistance.

One of the things that Dr. Traverso emphasized was the need to be able to communicate in English. The ability to communicate in English is and always has been a huge obstacle, not only for me but for

most Japanese doctors. While I was in Seattle, like my predecessors, I was given English lessons three times a week, and these spanned pronunciation, grammar, and even giving presentations. Thanks to these lessons, my English was slightly improved and I was able to complete my program.

I made rounds with residents starting around 6 AM every morning, I participated in morning conferences and lectures after that, and I observed surgeries on Mondays, Wednesdays, and Fridays. I attended the outpatient clinic on Tuesdays and Thursdays. Despite that busy schedule, I had English lessons and engaged in clinical research. Dr. Traverso was the first one to arrive at the hospital in the mornings and one of the last to leave at the end of each day. He was at the hospital even on Saturdays and Sundays, so I reported to him after he finished his work or on weekends. Once I concluded my report, he gave me another task to work on, so I tried very hard to fully complete each task.

The first task was to continue what my predecessor, Dr. Shinchi, had done: updating the Whipple procedure database. This project developed into an international multicenter web-based database (Whipple Pancreatic Anastomotic Leak Database, <http://pancreaticdata.org/>) designed to standardize the definition of pancreatic anastomotic leakage and establish a grading system for it. This work is still in progress. In addition, I did a study on pancreaticejunostomy performed with a surgical microscope and post-operative survival in cases of IPMN. Moreover, I was given an opportunity to present my findings at medical conferences, and Dr. Traverso gave me advice on how to make slides and write papers.

## 2. Mayo Clinic Rochester, MN

Mayo Clinic Rochester is the headquarters of three Mayo Clinics in the U. S., and it has been recognized many times as one of the best hospitals in the U.S. I was quite surprised that a hospital with such high-quality medical care and technologies is located in a small town in Minnesota. The medical facility alone does not make Mayo the high-quality hospital that it is. The medical services, medical system, and educational system play major roles. I found Rochester to be a safe town with beautiful natural surroundings. There are many Japanese, and the town offers a cozy environment.

My host doctor, Dr. Michael Farnell, is Chief of General Surgery there. He was very considerate and always took the time to make sure that I was alright despite his busy schedule. At Mayo, surgeons perform surgeries and see outpatients every other day, except Saturdays, Sundays, and holidays. Nevertheless, patients are referred to Mayo one after another, and on the days allotted, surgeons, together with residents, perform 4-5 surgeries per day. Two to three pancreatectomies per day are usual. Dr. Farnell performs rather aggressive surgeries, and he performs pancreatectomy combined with portal vein resection for pancreatic cancer. His surgical skills are wonderful, and I learned a lot by watching him perform the surgeries. When Dr. Farnell was not performing surgery, I was allowed to see Dr. David Nagorney perform hepatobiliary surgery, so the Mayo Clinic part of the Observership

was quite substantial. I decided to continue the Whipple database study that I started in Seattle, so I obtained data on Whipple cases from Dr. Farnell. I put the database from Seattle and Mayo together and analyzed data from 411 cases in total and presented my findings at the Pancreas Club 2005 at the end of the program.

### 3. UCLA, Los Angeles, CA

UCLA Medical Center is considered the No. 1 hospital on the West Coast. It is a large center located in front of UCLA's Westwood campus and adjacent to exclusive residential areas such as Bel Air and Beverly Hills.

Dr. Howard Reber, the host doctor there, is one of the opinion leaders in pancreatic surgery in the U.S. Many patients are referred to him from all over the U.S. At his outpatient clinic, from his conversations with patients and also in conferences, I got a glimpse of "the present standard in the U.S." He always answered my many questions very kindly. Dr. Reber's surgeries were performed with extraordinary carefulness, and even for pancreaticoduodenectomy, blood loss was often around 100 cc. I saw many cases of pancreatic cancer as well as surgical interventions for chronic pancreatitis.

At UCLA, I spent time sorting out data that I had gathered and writing papers, so I could not do any further research there. But I had a meaningful time attending conferences and workshops.

### 4. Conclusion

I learned a lot and experienced many things in the JSHBPS Observership program. Learning about differences in the medical system and the postgraduate medical education system between Japan and the U.S. was particularly meaningful. I feel that there is a little too much "rationalism" in the medical care system in the U.S. when it comes to healthcare costs. The best example is that for any surgery, a patient is admitted to the hospital on the day of the surgery, and once he/she can eat and walk and shows no sign of infection, he/she is discharged. In other words, hospital stay is kept to a minimum. The average hospital stay after pancreaticoduodenectomy, according to my data, was 11 days at VMMC in Seattle and 15 days at Mayo. Consequently, surgery tends to be performed with techniques associated with few complications, and extensive/aggressive surgeries are not performed very often. I often saw cases of pancreatic cancer with suspected portal vein involvement which I deemed to be "resectable" with portal vein resection and reconstruction, but resection was not considered an option. That is an example of the differences. All three hospitals that I visited were top-level medical facilities, but we should remember that there are numerous persons in the U.S. who cannot receive satisfactory

medical treatment. Japan has much to learn from the rational American medical system, but I realize that we need to be proud of Japan's national medical care system under which anyone can receive medical care equally.

I was most impressed with the postgraduate medical education system in the U.S. The daily life of surgical resident is not easy, but it is very fulfilling. At all three hospitals, there was a special lecture for residents almost every morning. These lectures covered everything from the basics to what was being discussed at medical conferences. At conferences, the residents are gradually trained to give presentations and lead discussions, so by the time a resident becomes a chief resident, he or she has the knowledge of a full-fledged surgeons. Most surgeries were performed by one staff surgeon and one resident. (I did not see a staff + staff combination unless it was for a special surgery such as a liver transplant.) Thus, residents are able to perform a large number of surgeries and acquire the necessary surgical skills. Residency is completed in 5 years ( $\pm 2$  years of basic research), and those who complete their residency don't necessarily stay in Surgery. Many residents undertake various fellowships to develop their expertise, but the pursuit of such fellowships is highly competitive. The JSHBPS Observership is another avenue by which young surgeons can expand their training, and I was very appreciative of the opportunity to see actual clinical practice in the U.S. and to experience firsthand the sincerity of American surgeons. The Observership was a remarkably stimulating experience, and it motivated me to train myself further.

I wish to express my heartfelt appreciation to Dr. Tadahiro Takada, who presented me with this wonderful experience, and to the host doctors who gave me the opportunity to learn. I also want to thank my family who supported me during my time in the program. I hope that this Observership will develop further and that more young doctors will have a similar, wonderful experience.

## Accomplishments during the Observership

### Academic Papers

1. Outcomes following resection of invasive and noninvasive intraductal papillary mucinous neoplasms of the pancreas. Wada K, Kozarek RA, Traverso LW. Am J Surg 189, 632-637, 2005.
2. Pancreatic anastomotic leak after the Whipple procedure is reduced using the surgical microscope. Wada K, Traverso LW. Surgery, submitted.
3. What is a clinically relevant pancreatic anastomotic leak after pancreaticoduodenectomy? A definition based on actual clinical outcomes. Shinchi H, Wada K, Traverso LW. J Gastrointest Surg, in press.

## Conference Presentations

1. Seattle definition of a pancreatic anastomotic leak. Pancreas Cancer 2004, Pisa, Italy, April 24-26, 2004 (oral presentation).
2. Eliminating pancreatic anastomotic leak after the Whipple procedure. 38th Pancreas Club 2004, New Orleans, May 16, 2004 (poster presentation).
3. Long-term outcome after surgery for invasive intraductal papillary mucinous tumors of the pancreas: a preliminary report. 38th Pancreas Club 2004, New Orleans, May 16, 2004 (poster presentation).
4. A clinically relevant definition of pancreatic anastomotic leak after pancreaticoduodenectomy. 45th SSAT. New Orleans, May 16-19, 2004. (poster presentation).
5. Long-term survival after resection for IPMN. 91st North Pacific Surgical Association, Tacoma, November 12-13, 2004 (oral presentation).
6. Pancreatic anastomotic leak after the Whipple procedure using duct-to-mucosa pancreaticojejunostomy. 39th Pancreas Club, Chicago, May 15, 2005 (oral presentation).



