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Letters to the Editor

Burnout among General Surgery Residents in the Region of Murcia☆

Burnout entre los residentes de Cirugía General de la Región de Murcia

We have read with interest the article published about the results of the national survey on professional burnout, with the participation of all General Surgery and the Digestive System residents in Spain.[1]

There is a higher incidence of burnout in young professionals who are excessively involved in their work and in 'helping professions', in which the confrontation with intense emotions of pain or illness is common. Thus, healthcare professionals are greatly affected, especially in their first years of work experience.

In the specific case of General Surgery residents, work stress can be related to numerous aspects associated with their training. These include the high workload and high level of responsibility and competitiveness, all of which are commonly associated with situations for which residents have not been prepared during their theoretical training.

In addition, high rates of burnout have been reported. According to a recent review,[2] 38.5% of General Surgery residents experienced symptoms of burnout at least once a week.

Due to all of the above, we decided to conduct a similar study among General Surgery residents in the region of Murcia. We used the Maslach Burnout Inventory[3] and the same form as the one used in the national study, with the participation of 23 residents who agreed to complete the study in our region.

In our analysis, we found high rates of 'feeling burned out' among CGAD residents in the region. Of those surveyed, 17.4% were diagnosed with burnout, and 82.6% of the sample presented a high risk to develop burnout syndrome in the future.

In addition, we conducted a sub-analysis asking whether it was more stressful to be at the beginning or at the end of training, since the level of stress and responsibility at both moments can overwhelm residents. Our study included 11 residents from years 3 to 5 (48%) and 12 newer residents from years 1 or 2 (52%); the level of work stress was elevated in both groups according to the Maslach Burnout Inventory (68 in the former and 65.5 in the latter), with no significant differences observed (P=.359). Our hypothesis is that both groups are subjected to a high level of stress, mainly due to the lack of days off after night shifts, stress related to the medical profession, a high level of involvement, etc.

The conclusions of our study support those of the Spanish study. Burnout is more frequent than desired among General Surgery residents in Spanish hospitals.

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Laparoscopic pancreaticoduodenectomy: May we illuminate some shadows?☆

Duodenopancreatectomía cefálica laparoscópica: ¿podemos iluminar algunas sombras?

Dear Editor,

We have read the recent article by Espín Álvarez et al., ''Highs and Lows in Laparoscopic Pancreaticoduodenectomy''.[1] First of all, we would like to congratulate the authors, not only for the results presented, but for their thoughts on such a widely debated topic: the incorporation into clinical practice of such a demanding procedure as minimally invasive pancreaticoduodenectomy (PD).[2]

When faced with this challenge in our unit, the safety of our patients was paramount.[3] Being aware of the Achilles' heel involved in performing pancreatic anastomosis, we designed a strategy based on stages that allows us to take advantage of our laparoscopic experience in hepatic and supramesocolic surgery (major and posterior segment hepatectomy, gastrectomy, distal pancreatectomy, splenectomy, etc) for the first phase of PD (laparoscopic phase). Subsequently, the 3 anastomoses are carried out in open surgery through a supraumbilical midline minilaparotomy. With this hybrid surgery concept (laparoscopic/laparotomic),[4] we have operated on our first 10 patients in 2019, whose median hospital stay was 6 days (5–10); there was only one case of readmission for grade C fistula (unpublished data) and no 90-day mortality. In the laparotomic phase, we always perform the pancreatic division and the release of the retroportal lamina for better control of the drainage veins from the head of the pancreas to the mesenteric-portal trunk. On many occasions, this leads to non-progression during laparoscopic dissection, requiring conversion, as happened to the authors with one of their patients.

From the results presented, it is striking that the median stay of the group that underwent open PD was almost double the hospital stay for laparoscopic PD (15 vs 8.5 days). Meanwhile, the incidence of complications was only slightly higher (without reaching statistical significance) in the group of patients with open surgery. As the authors well argue, this was probably related to the patient selection, as the patients in the open surgery group had greater technical complexity or comorbidities.

We believe that the possibilities of developing laparoscopic PD in our units should be based on previous experience in open pancreatic surgery, careful patient selection (as shown in recent consensus documents[5,6]), specific training programs for the procedure,[7] and an implementation strategy in which hybrid PD, such as our approach, has a place on the learning curve.[8] With this roadmap, perhaps we can illuminate and eliminate some of the shadows that still haunt us.

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