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# EDITORIAL – I

Assessment of Post MenopausalBleeding (PMB) is an important domain of the sonologist because the common causes of postmenopausal bleeding like endometrial carcinoma, endometrial polyp, cervical cancer, cervical lesion, foreign body and infection, uterine tumours, ovarian cancer can be detected quite fairly by sonography.

Diagnosis of postmenopausal bleeding is started with detailed history taking e.g. age, obesity, associated diseases like diabetes, family history of menorrhagia, frequency, length, quality of bleeding, whether patient is on HRT or steroid therapy etc. Leukaemia, blood dyscrasia or even an overdose of anticoagulant might present as PMB.Next pelvic examination and Pap Stain is essential. Non-invasivediagnostic procedure includes pelvic Ultrasound or Trans Vaginal Ultra Sound (TVS) to measure the endometrial thickness. TVS is an excellent screening tool with sensitivity 91% and specificity 96%. The endometrial thickness between 8 and 15 mm. is considered to be suspicious. Sometimes Saline Infusion Sonography (SIS) is required to see the endometrial polyp.

Ultrasound examination can assess the uterine, cervical and adnexal mass. Invasive procedure includes endometrial biopsy and cervical biopsy. Endometrial biopsy being easy to perform and numerous sampling devices available, acclaims a sensitivity of 90 – 95%. Colour Doppler Velocimetry in the postmenopausal uterus is also required. Vascular supply of the uterus is affected by the aging process of the uterine perfusion. The vascular compliance is lower in spontaneous menopause as shown by lower diastolic flow. The decrease of the vascular compliance is caused by progressive sclerosis of vessel wall. Visualisation of Doppler signal from the spiral artery is possible in less than 1/3$^{rd}$ postmenopausal women.

Women with PMBshould not be neglected and needs definitive thorough investigation and proper management as in postmenopausal women endometrium regresses and no bleeding should occur otherwise.

Dr. A. K. Roy

# EDITORIAL – II

Nowadays, despite the fact that on cosmetological point of view Laporoscopic Cholecystectomy is preferred over open-Cholecystectomy operations, the former has been unfortunately vitiated by some eventful situation as well as complication that has necessiated proper intra-operative evaluation of the biliary tree. The associated incidences of bile-duct injury which approximates two to four times as of open surgery is strongly related to the surgeon's experience, the anatomical distortion due to extreme traction at the Heartman's pouch, short cystic duct causing tenting of the the common bile-duct that simulates the cystic duct, inadequate exposure of the ctritical structures in the Calot's triangle and novice assistant's inadvertent exposure of common hepatic duct or common bile duct as the cystic duct or excessive use of diathermy. Moreover retention of stone in common bile duct adds to the menace. Also, bleeding during Laporoscopic Cholecystectomy lays emphasis on the importance of Laporoscopic Ultrasonography during the aforesaid operative procedure.

This new technology in evolution of hepatic, pancreatic & biliary system uses the same principle as endoscopic instruments in which the endoscanners has flexible tips that allow better tissue contact thus optimising acoustic coupling, so as to enable the surgeon to scan the field in multiple planes. In addition, it has been found that Laporoscopic Ultrasonography is highly accurate, safe, simple, replacing and exceeding the tactile sense of open surgery with avoiding stectomythe mis-interpretation and complications of intra-operative cholangiography. Moreover the procedure and the technology as a whole serves as a road map to the billiary-system preventing thereby bile duct injury by demonstrating the relationship of the circular images of common bile-duct, nearby hepatic artery and the portal vein which has been described as Mickey Mouse head, also in cases of failed ERCP or in cases where the process is contraindicated it is a handy procedure in detection of ductal stones. Lastly, Laporoscopic Ultrasonography can not only handle and minimise intra operative bleeding through facilitating accurate dissection and minimising electrocautary dissection, but also can help to distinguish ductal and vascular structures thereby decreasing the conversion rate of Laporoscopic Cholecystectomy to open surgery.

Last but not the least; the ease of visualizing the pancreatic duct, the ampullary portion of the common bile duct and the ampulla of Vater which is possible by utilizing this new technology is difficult with the camera and the instruments used in Laporoscopic Cholecystectomy.

Hence it can be opined that, Laparoscopic Ultrasonography will soon be a part and parcel not only in Lap. cholecystectomy but other lapwell. Operations as a whole, and the research as well as applicability of this procedure is having a long way to go.

Dr. A. K. Bhusena