Myths in General Surgeons Working at Muhammad Medical College Hospital and other hospitals of Mirpurkhas.

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Abstract:

Background: According to the Webster's New International Dictionary, a myth is "A belief given uncritical acceptance by the members of a group especially in support of existing or traditional practices." Clinical decisions should, as far as possible, be evidence based. So runs the current clinical dogma.

Methodology: A cross sectional study was conducted among the surgeons of MMCH and other hospitals of Mirpurkhas. Data was collected with the help of pre checked questionnaire which was developed by Jefferson scale.15 common surgical myths were selected from "PRACTICE COMMENTARY OF SURGICAL ROUNDS" published in January, 2004

Results: Study was conducted among the 21 General surgeons of MMCH and other hospitals of Mirpurkhas showed high incidence of myth following, ranging from 14.2 to 85.7.

Conclusion: On the basis of our study we conclude- ed that there is resistance to applying the guidelines among surgeons.

Key Words: Surgical myths, Surgeons, Evidence based practices, MMCH.

Introduction:

According to the Webster's New International Dictionary, a myth is "A belief given uncritical acceptance by the members of a group especially in support of existing or traditional practices[1].We are urged to lump all the relevant randomised controlled trials into one giant meta -analysis and come out with a combined odds ratio for all decisions[2,3].

Methodology: A cross sectional study was conducted among the surgeons of MMCH and other hospitals of Mirpurkhas. Data was collected with the help of pre checked questionnaire. 15 common surgical myths were selected from "PRACTICE COMMENTARY OF SURGICAL ROUNDS" published in January, 2004[4].

Result:

Study was conducted among the 21 General surgeons of MMCH and other hospitals of Mirpurkhas showed high incidence of myth following, ranging from 14.2 to 85.7.

MYTHS	STRONGLY DISAGREE	IN BETWEEN	STRONGLY AGREE
Patients should be kept nil by mouth after GI surgery.	28.5%	28.5%	42.8%
GI decompression is essential and protective after GI surgery.	28.5%	42.8%	28.5%
Bowel obstruction never let the sunset on it.	28.5%	14.2%	57.1%
Two layered intestinal anastomosis safer than a single anastomosis.	57.1%	28.5%	14.2%
Leaving peritoneal drains in place after operation for local/diffuse peritonitis is beneficial.	14.2%	57.1%	28.5%
Wound dressing should be daily changed.	57.1%	42.8%	0 %
Full course antibiotics should be given starting in ward to prevent SSI.	28.5%	42.8%	28.5%
Irrigating the peritoneal cavity after any type of operation is beneficial.	28.5%	42.8%	28.5%
Incisions heal from side to side, not from end to end, thus length doesn't matter.	57.1%	14.2%	28.5%
Spinal injuries are permanent.	28.5%	28.5%	42.8%
It is impossible to safely repair late esophageal perforations.	28.5%	57.1%	14.2%
The bigger the incision, the greater the surgeon.	85.7%	14.2%	0 %
Layered abdominal closure is better.	14.2%	42.8%	42.8%
Subcutaneous sutures improve wound healing.	28.5%	28.5%	42.8%
All grossly contaminated wounds should be left open for delayed secondary closure.	14.2%	42.8%)	42.8%

Discussion:

It is 23 years since the evidence based medicine working group announced a "new paradigm" for teaching and practising clinical medicine.[2]As a result, the Cochrane Collaboration started collating and summarising evidence from clinical trials;[5] setting methodological and publication standards for primary and secondary research[6]building national and international infrastructures for developing and updating clinical practice

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guidelines;[7] developing resources and courses for teaching critical appraisal;[8] and building the knowledge base for implementation and knowledge translation.[9] Concerns were raised about findings from average results in clinical studies could inform decisions about real patients, who rarely fit the textbook description of disease and differ from those included in research trials.[10] But others argued that evidence based medicine, if practiced knowledgably and compassionately, could accommodate basic scientific principles, the subtleties of clinical judgment, and the patient's clinical and personal idiosyncrasies. Guidelines, developed through consensus but based on a combination of randomized trials and observational studies.[11] Subsequently, the use of personal care plans and step wise prescription of inhaled steroids for asthma increased,[12] and morbidity and mortality fell.[13] UK National Institute for Health and Care Excellence guidelines for prevention of venous thromboembolism after surgery has produced significant reductions in thromboembolic complications.[14]However, we still see the evidence of practicing myth. The incidence of arthroscopic washout of the knee joint, with no proven benefits without a known loose body, varies from 3 to 48 per 100 000 in England.[15]

Conclusion:

There is resistance to applying the guidelines among surgeons in Mirpurkhas. More discussions and CME training may be beneficial in getting rid of myth based practices and advancing to best evidence practices.

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