



**Manuel Alejandro García Girón, MD, Guatemala**

**ASCRS International Traveling Scholarship Report 2017**

My name is Manuel Alejandro García Girón, I am 34 years old and I live in Guatemala City. In 2008 I obtained my medical degree and in 2013 my master in general surgery, both from the Universidad de San Carlos de Guatemala. In 2016 I completed my postgraduate studies (fellowship) in coloproctology under the auspices of Dr. Jorge Latif, at the Clínica Modelo de Lanús in Buenos Aires, Argentina. Since my return to Guatemala early in 2016 I have been working as deputy chief of the Colorectal Unit at the Hospital General San Juan de Dios in Guatemala City. I was accepted into the Guatemalan Association of Surgeons and the Guatemalan Association of Colon and Rectal Surgeons, and have been elected to the board of directors as spokesman.

In Guatemala, there are 10 hospitals with general surgery training programs, but of those hospitals, only three are third level hospitals and all of them are located in Guatemala City. There are no colorectal training programs available. If a Guatemalan surgeon wants to pursue a career in coloproctology, he has to look for opportunities abroad.

Guatemala has a population of 16 million people. The public health system is divided into three levels. The first level consists of "Health Posts" and "Health Centers" attended by general physicians or medical students and are located in the most rural parts of the country. The second level consists of "Regional Hospitals" attended by specialized doctors (general surgeons, pediatricians, OB-GYN, etc.) and located in small cities. And the third levels consist of two third level hospitals with medical subspecialties (coloproctology, nephrology, cardiology, etc.)

There are only 22 colorectal surgeons in Guatemala, and only 6 of us work in the public health system or in social security hospitals. This is due to low pay and having no benefits available to doctors working the public health system. Maybe the biggest challenge in treating colon and rectal diseases in Guatemala is the high percentage of poverty and few doctors trained to treat them working in the public health system. Seventy percent of our population is poor, only having access to the public health system.

Our health system is also underfunded. Our equipment is outdated, we lack appropriate laparoscopic equipment, we do not have endorectal and endoanal ultrasound or manometry and we lack the capacity to establish a CCR screening program. When it comes to treating CCR we don't have MRI, and often our CT is out of order for weeks at a time. Sometimes we run out of chemotherapy medication, and we do not have biologics and radiotherapy.

After visiting the United States and having the opportunity to attend the ASCRS Annual Scientific Meeting, I realized that the way in which we treat colorectal disease,

especially colorectal cancer, in the public health system is not adequate at all. The lack of funds and equipment is directly affecting the outcome of our patients. That is why I have decided to create awareness of this situation at my institution, starting with the head of the department and the director of the institution.

Attending the ASCRS Annual Meeting gave me the opportunity to learn a great deal about laparoscopic surgery, robotic surgery, AIN and HRA and ERAS. I learned a lot about these topics and I believe that this knowledge can be shared with my colleagues.

The AIN and HRA workshop was an excellent workshop and I learned a lot. I believe that one of the most important parts of the workshop was the Hands-On portion. The professors also shared amazing tips and tricks that will be of great benefit to me. It was a great experience for me and I think that it is going to have the greatest impact in my practice since we are planning to create an anal cancer screening program at my institution.

I also had the opportunity to learn about the benefits of laparoscopic surgery and robotic surgery. I attended the Debate on the Optimal Approach for Treating Rectal Cancer. It was really insightful, and it opened my eyes to the great benefits of minimally invasive surgery for rectal cancer. I have had some experience with laparoscopic surgery before, but it was the first time that I had the opportunity to see and try a robot. From now on I will favor the use of minimally invasive surgery for all colorectal surgery in my institution.

The main differences between the U.S. and Guatemala when it comes to practicing colon and rectal surgery are that in Guatemala there is a lack of data and original research, a lack of trained colorectal surgeons and the extremely low salaries in the public health system.

I was amazed at the amount of data that is collected at the U.S. institutions. It allows for great papers and posters to be published and to accurately analyze your outcomes. In Guatemala, there is no incentive to collect data or to publish scientific papers and there is no access to public or private research funds. That is the reason why our biggest public health hospitals produce zero research.

Maybe ERAS is the one thing that can more easily be adopted at my institution since it does not require a lot of funds and equipment. On the other hand, minimally invasive surgery requires a great investment and might be more difficult to implement, but I think that now I have the opportunity to share what I have learned with others and make them realize that minimally invasive surgery is not a trend but a necessity for our institution. And last but not least is anal cancer screening and HRA. The chair of my department is interested in starting an anal cancer screening program at my institution. Since I had the chance to attend the AIN and HRA workshop, I believe we are a little bit closer to achieving our goal, we just need to acquire the equipment.