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Laparoscopic repair of acquired lumbar hernia

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Abstract

Lumbar hernias are rare; approximately 300 cases have been described in the literature since their first description. They are typically subdivided by categories such as congenital or acquired and by their location. Acquired lumbar hernias may follow trauma, poliomyelitis, loin incision, and the use of iliac crest as a donor site for bone grafting. Although they tend to grow in size and have a 25% risk of incarceration and 8% risk of strangulation, surgery is indicated once the lesion is confirmed. Many techniques have been described for surgical repair of lumbar hernias, including primary repair, local tissue flaps, and conventional mesh repair. All these open techniques require a large incision plus extensive dissection to expose the area. The first laparoscopic repair of lumbar hernia was described in 1996. The laparoscopic approach for lumbar hernia has significant advantages: it enables exact localization of the anatomic defect, the mesh can be placed deep into the defect allowing intraabdominal pressure to hold it in position, and it also has all the well-known advantages of the laparoscopic approach. We present two cases of laparoscopically repaired acquired lumbar hernias.

Key words: Lumbar hernia — Laparoscopy — Hernia — Acquired lumbar hernia

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Occult gastrointestinal bleeding and abdominal pain due to entero-enteric intussusception caused by splenosis

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Abstract

Intussusception is rare in adults. We report the first known case of adult intussusception caused by splenosis. The patient had chronic gastrointestinal bleeding and intermittent abdominal pain. The diagnosis of entero-enteric intussusception was made by CT scan. A laparoscopic-assisted small bowel resection was performed, leading to resolution of the symptoms.

Key words: Adult intussusception — Splenosis — Occult gastrointestinal bleeding — Laparoscopy

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Right hemihepatectomy for bile duct injury following laparoscopic cholecystectomy

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Abstract

Laparoscopic cholecystectomy (LC) has become the treatment of choice for patients with symptomatic cholelithiasis. But with the introduction of this technique, the incidence of bile duct injuries has increased. We report the case of a 33-year-old man who was transferred from an affiliated hospital to our department for the treatment of a bile duct injury 2 weeks after LC. Prior to transfer, a laparotomy had been performed, with insertion of a T-tube and a Robinson drain on day 5 after LC. Endoscopic retrograde cholangiography (ERC) on admission day revealed an extensive defect of the right biliary system, which could

not be treated endoscopically. An emergency laparotomy had to be performed at night for acute bleeding from the portal vein. Due to massive inflammation in the porta hepatis and intraparenchymal destruction of the right bile duct, liver resection was performed 2 days later, after the patient had stabilized in the intensive care unit (ICU). The patient had a prolonged postoperative course, but he finally recovered well from these operations. In conclusion, the management of bile duct injuries should include ultrasound to detect and drain fluid collections and ERC to classify the injury. Emergency laparotomy should never be performed without these examinations, since the majority of bile duct injuries can be treated endoscopically. Surgery for this serious complication should always be performed at specialized centers for hepatobiliary surgery.

Key words: Laparoscopic cholecystectomy — Bile duct injury — Hemihepatectomy — Liver resection

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Laparoscopic resection of type I choledochal cyst

Report of two cases in children

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Abstract

Type I choledochal cyst is a rare saccular or fusiform congenital dilatation of the extrahepatic biliary tract. It is usually treated by laparotomy at which the cyst is completely excised and a Roux-en-Y hepaticojejunostomy is performed to establish biliary enteric drainage. We report the laparoscopic excision and hepaticoduodenostomy of type I choledochal cyst in two girls aged 1 and 3 years. The entire procedure was performed laparoscopically using needlescopic instruments. A 7-mm telescope port was inserted at the umbilicus, a 3-mm port in the right upper quadrant, and a 6-mm port in left upper quadrant. An additional 3-mm fan-shaped liver retractor was passed through the abdominal wall without a trocar. The gallbladder and choledochal cyst was dissected and removed en bloc. The lower end of the common bile duct was closed with 5-0 polydioxanone. The duodenum was anastomosed to the common hepatic duct below the confluence of the right and left hepatic ducts. There were no intraoperative complications, and the children were asymptomatic with no episodes of cholangitis at 6 months follow-up. Pediatric surgeons trained in advanced laparoscopic techniques including intracorporeal suturing can perform laparoscopic repair of choledochal cyst safely.

Key words: Laparoscopic cyst excision — Choledochal cyst — Bilioenteric anastomosis

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Rupture of the lesser gastric curvature after a Heimlich maneuver

Laparoscopic repair

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Abstract

Background: We present a case of lesser gastric curvature injury after a Heimlich maneuver due to obstruction of the breathing tract that was repaired by laparoscopic surgery.

Methods: A patient with perforation of the lesser gastric curvature as a result of closed abdominal traumatism was operated on using the laparoscopic approach with the use of four trocars as work openings. With this technique, the diagnosis was confirmed, the injury repaired, and the abdominal cavity washed.

Results: The postoperative period was favorable and the patient was released from the hospital on day 7 without any complications.

Conclusions: Laparoscopic surgery can be technically reproduced in the treatment of gastric injury as a result of closed abdominal traumatism.

Key words: Heimlich maneuver — Gastric perforation — Laparoscopic surgery

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Hemobilia

A rare complication of laparoscopic cholecystectomy

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Abstract

Background: Laparoscopic procedures are safe and effective treatment methods in experienced hands. However, complications have been reported for laparoscopic procedures. One of the complications of laparoscopic cholecystectomy is vascular injuries. Hepatic and cystic artery injuries may occur alone or in association with bile duct injury. Bleeding from arterial injury may be seen during operation or in the late postoperative period. One of the most significant pathologies leading to this rare phenomenon is hemobilia.

Methods: We present a case of a 62-year-old woman who underwent routine laparoscopic cholecystectomy for cholelithiasis at another hospital. She presented 6 months later with the clinical feature of upper gastrointestinal bleeding.

Results: There was a 42 × 40 × 11 mm anechoic lesion and an echoic pattern compatible with a metallic object was found in the subhepatic region using abdominal ultrasonography. In the endoscopic examination, fresh blood was found in the stomach. The source of hemorrhage could not be identified. Bulbus duodeni was normal but a fresh clot on the papilla of Vateri was seen on gastroduodenoscopic examination. Laparotomy was performed and the provisional diagnosis of hemobilia was reached. The injured hepatic artery and pseudoaneurysmatic structure were repaired.

Conclusion: Hemobilia is a late complication of laparoscopic cholecystectomy. We believe that it is important to take into consideration that bile duct injuries may be accompanied by arterial pathology.

Key words: Laparoscopic cholecystectomy — Hemobilia

Correspondence to: O. Dogru

First report on sequential totally endoscopic thymomectomy and adrenalectomy using computer-enhanced telemanipulation

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Abstract

Background: Laparoscopic adrenalectomy is considered the standard method for removal of benign adrenal tumors, regardless of hormone activity. Minimally invasive surgery for thymomectomy aims at limited approaches, avoiding complete sternotomy or large thoracotomy.

Methods: We report on a case in which totally endoscopic thymomectomy and adrenal gland resection were performed sequentially using a computer-enhanced telemanipulation system within 3 weeks.

Results: Operating time was 4.5 h for totally endoscopic adrenalectomy and 1.5 h for totally endoscopic thymomectomy. The patient was transferred to the normal ward on the day of operation after either procedure and had an uneventful recovery. Pathology yielded no malignancy in both cases.

Conclusion: This report demonstrates the safety and feasibility of various totally endoscopic procedures performed sequentially.

Key words: Thymomectomy — Adrenalectomy — Minimally invasive surgery — Totally endoscopic surgery — Robotic surgery

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Mechanical small bowel obstruction precipitated by colonoscopy

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Abstract

Mechanical small bowel obstruction (SBO) is rare complication of colonoscopy. We present a patient who developed SBO 24 h after surveillance colonoscopy. Four years prior to this procedure, he had undergone augmentation cecocystoplasty with continent ileal conduit. He subsequently underwent laparotomy and lysis of a band adhesion that caused extrinsic compression of the ileum proximal to ileotransverse colostomy. We further review the literature, describe the salient features of colonoscopy-induced bowel obstruction, and identify the risk factors for this unusual complication.

Key words: Bowel obstruction — Complications — Colonoscopy — Ileocecal valve

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Laparoscopically assisted enterolithotomy for a gallstone ileus in an atypical location

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Abstract

Mechanical intestinal obstructions caused by gallstones occur in approximately 1% to 2% of cases. In most of the patients, the obstruction occurs at the ileocecal valve. However, gallstones may cause obstruction anywhere along the gastrointestinal tract from the stomach to the sigmoid colon. Laparoscopically assisted enterolithotomy can be used as a treatment method. This report describes a case in which a gallstone blockage caused a mechanical obstruction in an atypical location, which was successfully treated with a laparoscopically assisted approach.

Key words: Gallstone ileus — Laparoscopy — Intestinal obstruction — Gallstone

Correspondence to: J. B. Lichten

Laparoscopic approach to the management of intraabdominal unicentric Castleman's disease

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Abstract

Castleman's disease, or angiofollicular lymphoid hyperplasia, is a rare lymphoproliferative disorder of unknown etiology. We present the case of an 18-year-old woman who was admitted with symptoms of fatigue, weakness, early satiety, and weight gain. A subhepatic mass anterior to the pancreas was discovered on ultrasound. After being treated via the laparoscopic approach with complete surgical resection she recovered well. This case thus represents a new application for laparoscopy and expands the indications for its use.

Key words: Castleman's disease — Laparoscopic surgery — Lymph nodes — Angiofollicular lymphoid hyperplasia

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Laparoscopic tension-free hernioplasty for lumbar hernia

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Abstract

Lumbar hernia, a defect of the posterior abdominal wall, is a very rare condition. The repair of a posterior abdominal wall hernia by simply closing the hernia port with sutures may not be adequate, especially when the herniation is due to a weakness in the abdominal wall. Recently, a simple, logical method of tension-free repair has become a popular means for the treatment of various abdominal wall hernias. Previous studies have advocated the use of tension-free repair for lumbar hernia; the technique uses a mesh replacement and requires an extensive incision. Herein we present a case of superior lumbar hernia. Our technique consisted of a laparoscopic tension-free hernioplasty with the application of a Prolene mesh. This technique, which provides an excellent operative view, is safe, feasible, and minimally invasive. We conclude that laparoscopic tension-free repair should be the preferred option for the treatment of lumbar hernia.

Key words: Lumbar hernia — Laparoscopy — Tension-free hernioplasty — Prolene mesh

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Prolonged abdominal wall pain caused by transfascial sutures used in the laparoscopic repair of incisional hernia

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Abstract

The use of transfascial sutures in the laparoscopic repair of incisional hernia has considerably facilitated the accurate intraperitoneal placement and fixation of the synthetic mesh. The laparoscopic procedure has a number of advantages, including less morbidity and pain. Moreover, the use of a mesh prosthesis results in a low rate of hernia recurrence. Despite the benefits associated with this technique, several (minor) complications have been documented. Herein we describe a case of prolonged abdominal wall pain after laparoscopic hernia mesh repair that was caused by the use of transfascial sutures.

Key words: Transfascial sutures — Laparoscopy — Incisional hernia — Complications

Correspondence to: J. Vermeulen

Laparoscopic treatment of Bochdalek hernia without the use of a mesh

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Abstract

Bochdalek hernia is a rare pathology. The preoperative diagnosis is difficult, and few reports are available regarding its treatment. Herein we report the case of a 25-year-old woman referred for symptoms of dyspepsia, dysphagia, and thoracic pain exacerbated by pregnancy. Preoperative radiography, EGD, and CT scan revealed a paraesophageal hiatal hernia. Laparoscopic exploration showed the complete thoracic migration of the stomach through a left posterolateral diaphragmatic foramen. The diagnosis of a Bochdalek hernia was then made. The diaphragmatic defect was repaired without inserting a prosthesis, using five separate non-reabsorbable stitches (Rieder technique). The procedure was completed with a Nissen-Rossetti fundoplication. The duration of the procedure was 150 min. Hospital stay was 12 days. There were no complications. Postoperative Gastrografin radiography of the esophagus and

stomach showed a normal-shaped fundoplication and confirmed the subdiaphragmatic location of the stomach. We conclude that the laparoscopic approach represents the gold standard for the diagnosis and treatment of Bochdalek hernia and any associated complications.

Key words: Laparoscopy — Bochdalek — Diaphragmatic hernia

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Unusual presentations of spilled gallstones

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Abstract

Perforation of the gallbladder with resultant spillage of gallstones is not an uncommon occurrence. Spillage is reported to occur in 6% to 40% of laparoscopic cholecystectomies. Although not generally considered a significant problem, retained gallstones may cause serious complications years after the operation, with a clinical presentation that often is confusing. We report two cases of unusual complications from spilled gallstones. The first patient presented with clinical and radiologic findings of acute appendicitis 8 years after the laparoscopic cholecystectomy. The second patient presented with spontaneous erosion of spilled gallstones through the back 2 years and 9 months after the laparoscopic cholecystectomy. The literature is reviewed, and the management of spilled gallstones is discussed briefly. Although the complication rate is low, every effort should be made to retrieve spilled gallstones, and the event should be recorded in detail in the operative record. Obligatory conversion to an open procedure is not necessary.

Key words: Laparoscopic cholecystectomy — Spilled gallstones — Retained gallstones

Correspondence to: B. Okamoto

A thoracoscopic view of the nerve of Kuntz

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Abstract

The nerve of Kuntz and alternate neural pathways (ANPs) have long been considered crucial for upper limb sympathetic supply. However, at thoracoscopy, these structures are neither consistently identified nor

searched for. This is probably reflective of the effectiveness of an isolated second thoracic ganglionectomy for upper limb sympathectomy. We present the case of a 19-year-old male who underwent a second thoracic ganglionectomy for palmar hyperhidrosis. On the left side, approximately 2.5 cm lateral to the typically located sympathetic chain, a filamentous structure (one-quarter the diameter of the sympathetic chain), identified as the nerve of Kuntz, was noted coursing across the neck of the second rib.

Key words: Thoracoscopy — Nerve of Kuntz — Alternate neural pathway

Correspondence to: K. S. Satyapal

Combined laparoscopic-assisted right hemicolectomy and low anterior resection for synchronous colorectal carcinomas

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Abstract

Background: Two cases of combined laparoscopic-assisted right hemicolectomy and low anterior resection for malignancy are presented to illustrate the technical aspects of performing two concurrent laparoscopic-assisted bowel resections with sequential anastomosis. Although there are similarities with laparoscopic-assisted total proctocolectomy, the need for complete mesenteric dissection in two areas, removal of two separate specimens containing malignancy, and the need for two anastomoses raise unique technical considerations which include port placement, sequence of dissection, choice of specimen extraction sites, specimen handling, and sites for extracorporeal anastomosis.

Methods: Operative notes, operative videotapes, and hospital inpatient and outpatient records were reviewed for both patients.

Results: Laparoscopic-assisted combined resection was completed in both patients. In both cases, laparoscopic total mesorectal excision was performed. Maximum incision length was 6 cm. Both patients were ready for discharge on postoperative day 3.

Conclusion: Combined laparoscopic assisted right colectomy and low anterior resection can be performed for synchronous colorectal malignancies with curative intent.

Key words: Laparoscopy — Laparoscopic colectomy — Laparoscopic total mesorectal excision — Colon cancer — Rectal cancer — Surgery

Correspondence to: D. M. Lauter

Laparoscopic extraperitoneal excision of a nerve sheath tumor of the spermatic cord

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Abstract

A 60-year-old male presented with a nontender irreducible mass in the right groin. Examination revealed swelling in the inguinal canal in the region of the deep inguinal ring. He underwent laparoscopic, extraperitoneal exploration of the spermatic cord, where a soft tissue tumor was identified and excised. Histological examination confirmed a nerve sheath tumor. Nerve sheath tumors are uncommon neoplasms of peripheral nerves, which theoretically can arise from any nerve fiber but have only been described in the spermatic cord in three reports in the literature. We are not aware of any reports describing their excision either laparoscopically or by the extraperitoneal route.

Correspondence to: M. E. Bailey

Laparoscopic treatment of pancreatic insulinoma

From enucleation to distal pancreatectomy

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Abstract

Laparoscopy and laparoscopic ultrasonography (LUS) have been proposed for the diagnosis and treatment of pancreatic insulinoma. We present for cases of pancreatic insulinoma approached by laparoscopy guided by LUS. In three cases, insulinomas were in the pancreatic body and in one case in the pancreatic head. All lesions were detected preoperatively by abdominal US and confirmed by computed tomography. Laparoscopy was performed under general anesthesia. LUS was performed using a 10-mm flexible probe. In two cases the adenoma was enucleated using scissors and electrocoagulation, major vessels were controlled using clips, and enucleation was completed using a 30-mm endo-GIA. In one case a laparoscopic distal pancreatectomy with spleen preservation was performed. In one case the adenoma was deep in the pancreatic head; minilaparotomy was performed and the adenoma enucleated. Patients were discharged in good health 5–7 days after surgery. The postoperative course was complicated in one case of enucleation by peripancreatic fluid collection that was treated percutaneously. Our experience confirms that accurate localization followed by excision of tumors via the laparoscopic approach constitute a significant advance in the management of insulinoma.

Key words: Insulinoma — Laparoscopic distal pancreatectomy — Laparoscopic enucleation — Laparoscopic sonography

Correspondence to: O. Goletti

Resection of presacral ganglioneurofibroma by laparoscopy

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Abstract

Background. Tumors of the retrorectal space are rare. They comprise a heterogeneous group of benign or malignant tumors that cause similar symptoms due to their location in presacral space. If possible, complete surgery excision is the therapy of choice mainly through a sacral, abdominal–sacral, or a pure abdominal or perineal axis.

Case report. A 15-year-old asymptomatic patient was diagnosed with a retrouterine tumor during her first gynecological examination. Magnetic resonance imaging of the pelvis showed a 10 × 8.5 × 7-cm encapsulated presacral tumor. Retrorectal ganglioneurofibroma was removed by laparoscopy with preservation of the sympathetic and parasympathetic nerves and the sacral roots of the ischiadic nerves. No sensory or motoric dysfunction of the legs, bladder, or rectum was observed postoperatively.

Conclusion. This is the first case report of a complete endoscopic removal of large presacral ganglioneurofibroma in an asymptomatic woman.

Key words: Ganglioneurofibroma — Laparoscopic removal — Retrorectal tumors

Correspondence to: A. Schneider

Endoscopic sphincterotomy for cholangitis after recent coronary artery bypass graft surgery

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Abstract

It is particularly attractive to perform endoscopic retrograde cholangiopancreatography (ERCP) with sphincterotomy for cholangitis due to common bile duct stone because of the increased morbidity and mortality of the alternative therapy of choledochal exploration. The safety of therapeutic ERCP after recent myocardial injury is unknown since there are only five previously reported cases. Three patients underwent therapeutic ERCP after recent coronary artery bypass graft surgery for indication of recent cholangitis due to choledochal

stones. Initially, the cholangitis was managed medically in all patients. Endoscopic sphincterotomy (ES) was performed 11, 17, and 14 days after coronary artery bypass graft surgery. The calculi were successfully extracted by sweeping the choledochus with a balloon-tipped catheter or basket in all cases. During ERCP the vital signs remained stable; no cardiac arrhythmias, hemorrhage, or pulmonary complications occurred. Our

study demonstrates that therapeutic ERCP is not absolutely contraindicated after recent myocardial injury and suggests that ES is preferable to surgery for cholangitis due to common bile duct stones.

Key words: Endoscopic sphincterotomy — Coronary artery bypass graft surgery — Anticoagulation — Endoscopic retrograde cholangiopancreatography
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