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SURGICAL ENDOSCOPY and Other Interventional Techniques

Small bowel perforation after incomplete removal of percutaneous endoscopic gastrostomy catheter

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Abstract
Percutaneous endoscopic gastrostomy (PEG) is a well-established technique for providing long-term nutritional support. The advantages and most frequent complications have been widely documented, but less is known about the danger of removing or replacing a PEG by cutting the device at skin level without endoscopic assistance to ensure the removal of the inner part. Laparotomy is often required in elderly and high-risk patients to relieve an intestinal obstruction or perforation. We describe a fatal case of small bowel perforation, resulting from the inability to remove an inner bumper.
Key words: Peritonitis — Perforation — Bowel obstruction — Percutaneous endoscopic gastrostomy
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Choledocholithiasis caused by migration of a surgical clip into the biliary tract following laparoscopic cholecystectomy

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Abstract
As experience with laparoscopic cholecystectomy (LC) has increased, so have the number and variety of complications. We report a case of choledocholithiasis caused by migration of a surgical clip applied during LC. A 57-year-old Japanese man who had undergone LC 6 years previously was referred to our hospital with pruritus and jaundice. Magnetic resonance cholangiopancreatography and ultrasonography revealed a solid mass in the common hepatic duct and dilatation of the intrahepatic bile ducts. Abdominal arteriography demonstrated interruption of the right hepatic artery by surgical clips. Five days after a biopsy of the mass was performed through a percutaneous transhepatic biliary drainage tube, the mass moved to the terminus of the common bile duct along with one of the surgical clips. A basket catheter was used to remove the mass via endoscopy. Despite the fact that other clips in the common hepatic duct were partially exposed, the patient has been well for 2 years with no additional interventions.
Key words: Laparoscopic cholecystectomy — Choledocholithiasis — Surgical clip
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Laparoscopic distal pancreatectomy for Frantz's tumor in a child

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Abstract
Solid pseudopapillary tumor of the pancreas is a rare pathologic entity. Although the role of laparoscopy in surgery of the pancreas is still controversial, laparoscopic distal pancreatectomy has been reported with good results in adults. We report a laparoscopic spleen-preserving distal pancreatectomy in a 9-year-old boy who presented with a low-grade malignant tumor. Needle biopsy was impossible. A laparoscopic spleen-preserving distal pancreatectomy was performed. We

used four trocars, and the operative time was 240 min. Conversion to open surgery was not necessary. The boy's postoperative recovery was uneventful, and he was discharged on the 6th day. CT-scan control at 6 months was normal. This case shows that even in advanced surgical cases, such as spleen-preserving distal pancreatectomy, laparoscopic procedures can be done safely, within a reasonable operative time, in children.

Key words: Frantz's tumor — Pancreatectomy — Laparoscopy — Children

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Venocutaneous fistula

A new complication after laparoscopic cholecystectomy

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Abstract
This is the first description of venocutaneous fistula, a late complication of elective laparoscopic cholecystectomy that arose 18 months after the initial operation. Postoperatively, the patient twice developed an abscess in the abdominal wall at the former site of the umbilical trocar. The first abscess occurred on the 6th postoperative day; the second, after 14 months. After an additional 4 months, a fistula opening appeared just below the umbilicus. Fistulography revealed a connection with the venous system of the omentum majus. During subsequent resection of the fistula, a pigment gallstone was retrieved from the base of the fistula.

Key words: Laparoscopic cholecystectomy — Lost gallstone — Venocutaneous fistula — Late complications

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Mediastinal bronchogenic cyst treated by mediastinoscopic drainage

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Abstract
Bronchogenic cysts are rare congenital anomalies located in the mediastinum and lung parenchyma. We present the clinical findings and describe the mediastinoscopic treatment of a bronchogenic cyst at the subcarinal space in a 50-year-old man. CT revealed a lesion at the subcarinal space with soft tissue density. Initially, mediastinoscopy was performed for diagnostic purposes. Histopathological evaluation of biopsy material taken from the cyst wall confirmed that the lesion was a bronchogenic cyst. The cyst contents were drained and a sclerosant agent was applied to the cyst lumen via the drainage tube. Mediastinoscopy not only provides diagnostic information but can also be used safely in the treatment of anterior bronchogenic cysts in patients not amenable to a second operation.

Key words: Bronchogenic cyst — Mediastinoscopy — CT — Sclerotherapy

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Videothoracoscopic resection of intrathoracic neurogenic tumors

Report of two cases

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Abstract
Two cases of intrathoracic neurogenic tumors are discussed. The benign neoplasms were located in the posterior mediastinum and caused no clinical symptoms. In both cases, complete resection of the lesion was achieved by video-assisted thoracic surgery (VATS). There were no intraoperative complications. Postoperatively, one patient presented with Claude Bernard-Horner syndrome, which resolved spontaneously after 1 week. Although the great majority of mediastinal neurogenic neoplasms are benign, resection is necessary to prevent malignant transformation and intraspinal extension.

Key words: Videothoracoscopic resection — Intrathoracic neurogenic tumors

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Laparoscopic resection of an abdominal wall desmoid using a modified suture traction technique

The "marionette trick"

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Abstract
Desmoids are rare mesenchimal tumors that may originate also inside the abdomen or in the abdominal wall. These tumors are biologically characterized by a ten-

dency to local growth, and only rarely are they able to develop distant metastases. Surgical excision usually is the best treatment with a chance of a cure. In the few reports on intraabdominal or abdominal wall desmoids, open surgery always was performed. The first case of successful laparoscopic resection of a symptomatic anterior wall desmoid tumor with intraabdominal growth is reported. During the procedure, it was difficult to mobilize and grasp the mass using the common laparoscopic instruments, but with the help of the "marionette trick," modified suture traction technique, the tumor could be removed easily using only three trocars. With four traction sutures minimizing the wall trauma, the trick made it possible to mobilize the mass in at least, seven directions, according to the principles of physical forces and vectors. This simple trick can be helpful for other common laparoscopic procedures, avoiding the insertion of sometimes ineffective instruments through more traumatic trocars.

Key words: Abdominal wall — Desmoid — Surgery — Laparoscopy — Suture traction — Trick

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Fatal bile pulmonary embolism after radiofrequency treatment of a hepatocellular carcinoma

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Abstract

Radiofrequency is increasingly used to manage liver tumors. This report describes the case of a 74-year-old man who received two courses of percutaneous radiofrequency thermal ablation for a hepatocellular carcinoma over a 4-month period. He subsequently required computed tomography-guided drainage for an area of intrahepatic necrosis. During the procedure, hemobilia developed, followed by respiratory distress and collapse. The diagnosis of bile pulmonary embolism was established on the basis of high biliary acid concentrations in pulmonary fluid aspiration and blood plasma. Radiofrequency thermoablation provides local control of advanced liver tumors with low recurrence and morbidity. However, this interventional procedure risks damage to liver parenchyma involving vascular and biliary structures, which may lead to biliary–venous fistula and possible bile emboli.

Key words: Bile pulmonary embolism — Acute lung injury — Radiofrequency thermal ablation — Hepatocellular carcinoma

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Concomitant laparoscopic gastric and biliary bypass and bilateral thoracoscopic splanchnotomy

The full package of minimally invasive palliation for pancreatic cancer

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Abstract

Introduction: Pancreatic cancer is unresectable in 80% or more of patients. Biliary and duodenal obstruction and intractable abdominal and back pain are the most common complications of the disease. These complications may be palliated effectively using minimally invasive techniques. Their combined application in a single setting is presented and discussed in this article.
Case report: A 59-year-old man with a locally advanced carcinoma of the head of the pancreas presented with obstructive jaundice and intractable pain requiring opiate analgesia. An attempt at endoscopic biliary stenting was unsuccessful, and a percutaneous biopsy was deemed unsafe. Preoperative magnetic resonance cholangiography showed cystic duct insertion abutting the upper limit of the biliary stricture. A laparoscopic Roux-en-Y hepaticojejunostomy, prophylactic loop gastroenterostomy, and tumor biopsy were combined with a bilateral thoracoscopic splanchnotomy.
Result: Surgery and subsequent recovery were uneventful, and the patient was discharged from hospital on the fourth postoperative day off opiates. He remained free of jaundice and severe pain, until 6 months later, when he represented with jaundice, cachexia, and proximal small bowel obstruction secondary to multiple liver and peritoneal metastases. He underwent further palliative laparoscopic enteric bypass with resolution of the intestinal obstruction, but died of the disease 10 days later.
Conclusion: Laparoscopic gastric and biliary bypass and bilateral thoracoscopic splanchnotomy may be safely combined to provide an effective comprehensive minimally invasive palliation of incurable pancreatic cancer.

Key words: Jaundice — Laparoscopic gastric bypass — Laparoscopic biliary bypass — Thoracoscopic splanchnicectomy — Pancreatic cancer — Palliation

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Hand-assisted laparoscopic resection of serous cystadenoma of the pancreas

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Abstract

It is difficult to exclude the possibility of malignancy of pancreatic cystic tumors because a biopsy of the pan-

creas is hard to obtain. The indication of open surgery for those cystic tumors without evidence of malignancy is controversial. Therefore, laparoscopic or laparoscopically assisted procedure would be an adequate choice of treatment for cystic tumors of the pancreas. Hand-assisted laparoscopic distal pancreatectomy with preservation of the spleen and the splenic artery and vein was performed for two cases of pancreatic cystic tumors. Three ports and one hand port were used. After careful dissection and accurate hemostasis between the pancreas and splenic vessels, laparoscopic distal pancreatectomy was carried out using an endoscopic linear stapler. There were no perioperative complications. The pathological diagnoses were oligocystic serous cystadenoma and solitary cystic serous cystadenoma, respectively. Hand-assisted, spleen-preserving laparoscopic distal pancreatectomy with preservation of the splenic artery and vein is a feasible procedure for the treatment of benign or borderline-malignant cystic lesions of the distal pancreas.

Key words: Serous cystadenoma — Hand-assisted surgery — Distal pancreatectomy

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