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Volvulus of the gallbladder: laparoscopic detorsion and removal

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Received: 16 May 2002/Accepted: 22 October 2002/

Online publication: 10 September 2003

DOI: 10.1007/s00464-002-4521-x

Abstract

A 73-year-old woman who presented with symptoms of acute cholecystitis was found to have a gangrenous gallbladder wrapped in three complete rotations around its pedicle. Detorsion and removal of the gallbladder were accomplished laparoscopically. Our review of the literature found no other case in which this degree of torsion was successfully treated laparoscopically.

Key words: Laparoscopy — Volvulus — Torsion — Cholecystectomy

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Laparoscopic transduodenal papillosphincteroplasty

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Received: 13 February 2003/Accepted: 21 March 2003/

Online publication: 10 September 2003

DOI: 10.1007/s00464-003-4216-y

Abstract

In the past 20 years, the approach to biliary lithiasis has changed tremendously as a result of advances in endoscopic and laparoscopic techniques. The two most important open surgical techniques involve extraction of the stones from the common bile duct combined with choledochenterostomy and papillotomy followed by transduodenal papillosphincteroplasty. Ideally, the choledochotomy is followed by the insertion of a T-tube in the common bile duct. The transcystic approach has never been considered. The first endoscopic papillotomy was performed in 1973. Subsequently, it became the most widely used method for removal of common bile duct stones. In this report we explore the

possibility of performing a laparoscopic transduodenal papillosphincteroplasty, following the strict rules commonly used in surgery. After cholecystectomy, a Fogarty catheter, is introduced through the cystic duct. This is followed by a minimal duodenotomy, then incision of the papillar sphincter. In this surgical proposal, we do not intend to substitute technique, but this method should be considered the ultimate solution in the laparoscopic approach to cholecystic choledocholithiasis.

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Intrahepatic foreign body laparoscopic extraction

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Received: 4 February 2003/Accepted: 7 March 2003/

Online publication: 10 September 2003

DOI: 10.1007/s00464-003-4208-y

Abstract

An 11-month-old boy presented with an intrahepatic foreign body after ingestion of a sewing needle. Surgical management using an exclusive laparoscopic extraction was successful.

Key words: Foreign body ingestion — Sewing needle — Laparoscopy

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Diaphragmatic hernia resulting from injury during microwave-assisted laparoscopic hepatectomy

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Received: 17 October 2002/Accepted: 25 April 2003/

Online publication: 29 September 2003

DOI: 10.1007/s00464-002-4554-1

Abstract

A 31-year-old woman underwent microwave-assisted laparoscopic hepatectomy of the left lateral segment for focal nodular hyperplasia on January 14, 1998. On September 9, 1998, she felt continuous left abdominal pain and was admitted to our hospital for further examination. An upper gastrointestinal series showed converging folds of the greater curvature of the upper third of the stomach and craniad displacement of this portion. Thoracic magnetic resonance imaging showed herniation of the stomach into the pleural cavity. The patient was referred to our department, where she underwent surgery for a diaphragmatic hernia. The fundus of the stomach had escaped into the left pleural cavity through a defect in the diaphragm near where laparoscopic hepatectomy had been performed. The stomach was returned to the peritoneal cavity and the defect sutured. The patient's postoperative course was uneventful. Although diaphragmatic hernia after laparoscopic surgery is a rare complication, with the performance of more advanced laparoscopic procedures and the use of higher-technology tissue-destruction/hemostatic devices such as the microwave coagulator, more caution should be observed to prevent injury to adjacent organs such as the diaphragm.

Key words: Laparoscopic surgery — Microwave — Diaphragmatic hernia

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Ventriculopleural shunt: thoracoscopic placement of the distal catheter

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Received: 10 April 2003/Accepted: 7 May 2003/

Online publication: 29 September 2003

DOI: 10.1007/s00464-003-4225-x

Abstract

Ventriculopleural shunting is usually reserved for patients with limited options for shunt revisions. We report the case of a 16-year-old boy with posthemorrhagic hydrocephalus who required numerous shunt procedures. At the age of 6 years, a ventriculopleural shunt was inserted by an intercostal thoracotomy, and 4 years later replacement of the distal catheter was necessary. Recently, he presented again with a shunt malfunction due to migration of the pleural catheter. We describe a technique for performing the placement of the distal catheter under direct thoracoscopic vision by a peel-off needle into the unscarred thoracic cavity despite two previous pleural procedures. The postoperative course was uneventful. Thoracoscopic assistance in ventriculopleural shunt placement appears to be a safe and ef-

fective technique, offering several advantages over the open procedure: it is less invasive, allows a precise positioning of the thoracic catheter under visual control, and confirms appropriate function.

Key words: Hydrocephalus — Thoracoscopy — Ventriculopleural shunt

Correspondence to: S. Kurschel

Laparoscopic partial splenectomy for a splenic pseudocyst

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Received: 15 April 2003/Accepted: 24 May 2003/

Online publication: 29 September 2003

DOI: 10.1007/s00464-003-4227-8

Abstract

We describe a laparoscopic hemisplenectomy that was performed to treat a 21-year-old patient with a large splenic pseudocyst located in the upper splenic pole. The diagnosis was made by computed tomography and ultrasound, and surgery was performed with ultrasound scalpel, clips, and fibrin glue. Surgery lasted 70 min and did not require blood transfusions. The patient was discharged on postoperative day 3, and at 28-month follow-up there were no sequelae or recurrences. The laparoscopic approach is a valid alternative to laparotomy because the integrated magnified view enables the surgical team to perform surgery in a much shorter time and with greater hemostatic accuracy than the traditional technique.

Key words: Laparoscopic surgery — Splenic pseudocyst — Laparoscopic hemisplenectomy — Hemisplenectomy ultrasound scalpel

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Snaring of submucosal tumors of gastric fundus

Beware of iatrogenic perforations

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Received: 16 April 2003/Accepted: 24 May 2003/

Online publication: 29 September 2003

DOI: 10.1007/s00464-003-4228-7

Abstract

Submucosal tumors of the stomach are not uncommon. We present two cases of iatrogenic perforation after snaring large polyps in the gastric fundus. We discuss the probable etiology and review the literature regarding iatrogenic perforation in this location. Submucosal polyps situated in the fundus may produce pseudopedicle. Therefore, we recommend these be treated with

caution, and a combined endoscopic and laparoscopic approach is suggested.

Key words: Gastrointestinal stromal tumor — Iatrogenic perforation — Stomach

Correspondence to: J. Mathew

Renal artery clip dislodgement during hand-assisted laparoscopic living donor nephrectomy

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Received: 21 April 2003/Accepted: 24 May 2003/

Online publication: 29 September 2003

DOI: 10.1007/s00464-003-4230-0

Abstract

The main reason for conversion in laparoscopic donor nephrectomy (LDN) is perioperative bleeding. One of the advantages of hand-assisted laparoscopic donor nephrectomy (HDLN) is facilitated control in case of bleeding. This report describes two methods to avert conversion in HDLN in the case of abrupt major arterial bleeding. In the first case, during left HDLN the clips placed on the renal artery dislodged, and the surgeon managed to control the bleeding by compressing the focus of the bleeding with his finger. A balloon occlusion catheter was inserted through a groin incision in the aorta and advanced to the origo of the renal artery. Due to control of the hemorrhage, it was possible to close the renal artery stump by laparoscopic suturing, and a conversion was averted. The patient was discharged after 5 days, without signs of damage to the remaining kidney. In the second case, during right HDLN, the clips on the renal artery dislodged during stapling of the renal vein. The bleeding was controlled by finger compression and new clips were placed. The cuff of the artery was long enough to be clipped again. The patient was discharged after 5 days. Graft function was excellent in both cases. Major arterial bleeding can be controlled and managed in hand-assisted laparoscopic surgery. The use of a balloon occlusion catheter is an elegant way to avert conversion.

Key words: Hand-assisted laparoscopy — Donor nephrectomy — Conversion — Hand-assisted laparoscopic donor nephrectomy

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Anastomotic recurrence of rectal adenoma after anterior resection

A contraindication to transanal local excision

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Received: 14 May 2003/Accepted: 24 May 2003/

Online publication: 29 September 2003

DOI: 10.1007/s00464-003-4238-5

Abstract

Transanal local excision of posterior benign rectal tumors is usually safe. Here, we report a case of transanal excision of a posterior anastomotic recurrence of a rectal adenoma after a stapled anterior resection that resulted in perforation into the peritoneal cavity.

Key words: Transanal local excision—Rectal adenoma

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An extrapleural approach to the anterior mediastinum using video-assisted thoracic surgery (VATS)

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Received: 20 March 2003/Accepted: 29 April 2003/

Online publication: 29 September 2003

DOI: 10.1007/s00464-003-4511-7

Abstract

A lateral extrapleural approach via video-assisted thoracic surgery (VATS) was used in a patient suspected of having a benign tumor of right lobe of the thymus. The patient previously had undergone lung resection for pulmonary tuberculosis, and the ipsilateral thorax had contracted and dense pleural adhesions were likely to exist. Lateral extrapleural approach by VATS was performed successfully and is an alternative to open surgery in highly selected patients with anterior mediastinal lesions.

Key words: Video-assisted thoracic surgery — Anterior mediastinum — Extrapleural approach

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Laparoscopic ureterolysis and reconstruction of a retrocaval ureter

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Received: 25 March 2003/Accepted: 29 May 2003/

Online publication: 29 September 2003

DOI: 10.1007/s00464-003-4513-5

Abstract

A 32-year-old man was investigated for repeated episodes of right-sided flank pain. Ultrasonography showed a dilated right pelvicalyceal system and upper ureter as well as multiple gallstones; subsequent intravenous urogram demonstrated a retrocaval ureter. At surgery, a right-sided double-J ureteric stent was placed

under fluoroscopic guidance. Initially, three laparoscopic ports were used. The dilated pelvis and upper ureter were mobilized, followed by the lower ureter. The pelvis was transected and transposed anterior to the inferior vena cava. Reconstruction was carried out with an intracorporeally sutured anastomosis over the double-J stent. A fourth port was added for completion of cholecystectomy. The patient had an uneventful recovery and was discharged on the third day. Fourteen

months later he remains well, with a recent intravenous urogram showing regression of hydronephrosis. We review the previously reported cases of laparoscopic and retroperitoneoscopic reconstruction of retrocaval ureter to compare and contrast these minimal access approaches.

Key words: Laparoscopy — Retrocaval ureter — Ureteroureterostomy

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