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## Laparoscopic relief of obstructing folded muscular cuff after transanal pull-through for aganglionosis

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### Abstract

Transanal endorectal resection and colonic pull-through (TERPT) is a good technique for the management of Hirschsprung's disease. This procedure is feasible in the vast majority of patients and is associated with excellent results, early postoperative recovery, and no visible scars. We report the case of a patient who developed early postoperative severe constipation after TERPT due to unusual folding of the muscular cuff rim, which tightly narrowed the pulled-through colon. This complication was diagnosed and treated by laparoscopy. To prevent it, we recommend splitting of the aganglionic muscular cuff during TERPT.

**Key words:** Aganglionosis — Hirschsprung's disease — Newborn — Transanal pull-through — Soave procedure — Laparoscopy

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## Laparoscopic left hemihepatectomy for hepatolithiasis

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### Abstract

To assess the feasibility of hepatolithiasis treatment using laparoscopic liver resections, a prospective study of laparoscopic liver resections was undertaken in selected

patients with left intrahepatic stone disease. The patients underwent a laparoscopic left lobectomy to try to alleviate the symptoms of their disease. Two patients were operated on successfully. Mean blood loss was 400–600 ml. Laparoscopic resections are feasible methods of treatment for selected patients with left intrahepatic stone disease.

**Key words:** Laparoscopic — Liver resections — Hepatolithiasis — Intrahepatic stone disease

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## Management of an unclear bile duct stenosis

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### Abstract

It is frequently difficult to determine whether a bile duct stricture is benign or harbors a malignant tumor based on medical history alone. Therefore, cholestasis of unknown etiology requires a thorough diagnostic evaluation to make a definitive diagnosis and choose the best course of treatment for the patient. We report the case of a 42-year-old man who developed cholestasis 6 years after undergoing orthotopic liver transplantation for end-stage liver disease. The bile duct was dilated by interventional endoscopy, and a brush cytology was obtained. Cytology revealed an inflammatory reaction. Three months later, the stricture persisted. We performed a forceps biopsy, and the diagnosis of a cholangiocarcinoma was confirmed histologically. We conclude that a combined application of brush biopsy/forceps biopsy and endoscopic measures is essential in cases of bile duct strictures of unknown etiology. Occasionally, surgical confirmation may be required. In any case, a single brush cytology is insufficient for diagnosis.

**Key words:** Stricture — Bile duct — Diagnostic procedures — Liver transplantation — Cholestasis — Brush cytology

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## Retained appendicolith after laparoscopic appendectomy

### The need for systematic double ligation of the appendiceal base

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#### Abstract

Appendicoliths are considered to be strong indicators of appendicitis and the complications of appendicitis. We report the case of a 29-year-old woman who underwent a laparoscopic appendectomy for appendicitis with an appendicolith. The appendix was divided with a single ligation at the appendiceal base, and an appendicolith escaped into the pelvis. Thereafter, the patient suffered recurrent pelvic abscess. The diagnosis of retained appendicolith was made by repeated CT scans that revealed a mobile spontaneous calcification within the abscess. This postoperative complication could have been avoided if a systematic division of the appendix had been performed between double ligatures.

**Key words:** Appendicitis — Appendectomy — Laparoscopy — Appendicolith — Postoperative complications

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## Laparoscopic management of a small bowel perforation caused by a toothpick

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#### Abstract

A 58-year-old man underwent an emergency laparoscopic procedure for small bowel perforation with peritonitis after the ingestion of a wooden toothpick. Treatment consisted of laparoscopic removal of the foreign body, followed by lavage of the abdominal cavity and laparoscopic closure of the perforation, including omentoplasty. The patient recovered from peritonitis and was discharged from the hospital on day 14 after the operation.

**Key words:** Small bowel perforation — Foreign body ingestion — Toothpick — Laparoscopy — Emergency surgery

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## Laparoscopic hand-assisted pancreaticoduodenectomy

### Initial UK experience

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#### Abstract

**Background:** By and large, the limited world experience with laparoscopic pancreaticoduodenectomy (PD) has been unfavorable, but the laparoscopic hand-assisted approach to PD has recently shown promising results. We report the first successful UK experience with laparoscopic hand-assisted PD (LHAPD).

**Methods:** A 62-year-old man who presented with painless obstructive jaundice was found at endoscopy, to have an ampullary tumor. Preoperative biopsy specimens confirmed the diagnosis of an adenocarcinoma, and CT showed no evidence of either vascular involvement or metastatic disease. A staging laparoscopy showed no intraabdominal metastases, and an LHAPD was performed using a Gelport.

**Results:** The intraoperative course was uneventful. Two units of blood were transfused intraoperatively, but no postoperative blood transfusion was required. The operative time was 11 h (plus a 30-min break). The patient's postoperative recovery was uneventful except for superficial pressure sores over the buttocks and elbows. The patient resumed oral fluid and dietary intake on the 1st and 3rd postoperative days, respectively, and was discharged from hospital on the 9th postoperative day. Histology demonstrated an ampullary adenocarcinoma with clear resection margins and involvement of two of the 13 lymph nodes examined. At 2-month follow-up, the patient remains well and is receiving adjuvant chemotherapy.

**Conclusions:** LHAPD achieves good oncological clearance and can be performed safely in selected patients. The early promising results with this approach will undoubtedly encourage wider adoption of this procedure and are likely to widen the selection criteria.

**Key words:** Laparoscopic surgery — Ampullary cancer — Pancreaticoduodenectomy — Hepaticojejunostomy — Gastroenterostomy — Cancer

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