(FNA) of the pancreas requires experienced cytopathologists as well as advanced immunohistochemical assays to obtain a final diagnosis on a small amount of tissue. A 46-year-old man complaining of watery diarrhea and severe weight loss (more than 20 kg) for more than 1 year was admitted to our hospital due to severe diabetic crisis. Enlarged lymph nodes (2.5×1 cm) were found at the right axillary stations. Abdominal ultrasound revealed the presence of a large hyperechogenic mass, mainly located at the pancreatic head. Abdominal computed tomography scan confirmed a diffuse enlargement of the head and body of the pancreas associated with lymphadenopathy along the lesser gastric curvature. Percutaneous ultrasound-guided FNA of the pancreas as well as gross biopsy of the axillary lymph nodes were unable to identify the nature of the mass. Diagnostic laparoscopy was performed: several enlarged lymph nodes along the lesser gastric curvature were revealed. Multiple biopsies of the pancreatic head were taken and lymphadenectomy along the lesser curvature and the hepatic hilus was also performed. The definitive histopathological examination of the pancreatic specimen revealed a primary low-grade non-Hodgkin B cell pancreatic lymphoma. The postoperative course was unremarkable; the patient underwent systemic chemotherapy regime for low-grade B cell Hodgkin lymphoma and he was symptom free at 9-month follow-up.

Key words: Diagnostic laparoscopy — Pancreatic lymphoma

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Laparoscopic renal biopsy in bilateral pelvic kidney with chronic glomerulonephritis

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Abstract
Percutaneous needle biopsy under the guidance of ultrasound or computerized tomography is the most valuable method in the diagnosis of parenchymal kidney diseases. However, sometimes it can be difficult to perform in the presence of certain anomalies, anatomic variations, or medical problems. In the presence of bilateral pelvic kidney, which is a rare anomaly, laparoscopy can be used to obtain biopsy. Biopsy of kidney was planned in a 26-year-old woman who presented with a history of hypertension for 7 years and proteinuria with the diagnosis of nephrotic syndrome. For the biopsy, the laparoscopic approach was chosen since the patient had bilateral pelvic kidneys. Under general anesthesia, using three port sites, the right kidney was reached, which was located more anterior than the left one. Three biopsy specimens for histologic evaluation were taken with a Tru-Cut biopsy needle. No complications were encountered during or after the operation. The patient was ceased from urological follow-up after performing an ultrasound on the first postoperative day. This is the first case of pelvic kidney with chronic glomerulonephritis reported in the literature in which the histologic diagnosis was made with the help of laparoscopy. Laparoscopic kidney biopsy is a minimally invasive technique that can be done in cases with anatomic variations, making percutaneous needle biopsy impossible.

Key words: Pelvic kidney — Ectopia — Laparoscopy — Biopsy — Glomerulonephritis — Parenchymal disease

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Early small bowel obstruction complicating hand-assisted laparoscopic donor nephrectomy

An uncommon etiology

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Abstract
Laparoscopic donor nephrectomy is gaining widespread acceptance as a minimally invasive technique for kidney donation. Although it has been associated with decreased patient morbidity and more rapid recovery, it exposes patients to possible complications inherent in its transperitoneal route. We report a case of a small bowel obstruction secondary to midjejunal intussusception occurring on the third postoperative day after a hand-assisted laparoscopic donor nephrectomy. The intussusception proved to be idiopathic since no lead point was identified. The patient recovered without significant sequela after reduction of the intussusceptum. Postoperative ideopathic intussusception is an uncommon cause of bowel obstruction in adults. Surgeons that perform laparoscopic donor nephrectomy will need to remain vigilant for complications that can be associated with the intraperitoneal route of this technique.

Key words: Hand-assisted laparoscopy — Laparoscopic nephrectomy — Small bowel intussusception

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Laparoscopic treatment of a gastric outlet obstruction caused by a gallstone (Bouveret's syndrome)

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Abstract
Duodenal impaction of a gallstone after its migration through a cholecystoduodenal fistula is an uncommon cause of gallstone ileus described as Bouveret's syndrome. Surgical treatment is recommended, but the morbidity and mortality rates are nearly 60% and 30%, respectively. To reduce these rates using improved endoluminal surgery, a laparoscopically assisted intraluminal gastric surgery could be considered. A 74 year-old woman was admitted with typical Bouveret's syndrome. An intraluminal gastric laparoscopy was performed. The large stone impacted in the first duodenum was removed through the pylorus and pulled into the stomach. After its mechanical fragmentation, the stone was extracted with a sterile retriever bag through the main trocar. In the case of Bouveret's syndrome, treatment of the duodenal obstruction is mandatory. Surgical treatment of the cholecystoduodenal fistula still is controversial. We never perform a one-stage procedure, and we reserve a biliary operation for the patient who remains symptomatic. In this way, laparoscopically assisted intraluminal gastric surgery with transpyloric extraction of the stone can be a safe and interesting approach for this type of pathology.
Key words: Bouveret's syndrome — Gallstone — Gastric endoluminal surgery
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Intractable hiccup

An odd complication after laparoscopic fundoplication for gastroesophageal reflux disease

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Abstract
Intractable hiccup can be an unbearable circumstance and its treatment is often frustrating. More than 100 causes for hiccup have been described in the literature; the most common cause is gastroesophageal reflux disease (GERD). We report a case of a 31-year-old patient who suffered from intractable hiccup starting 3 weeks after laparoscopic Nissen fundoplication for GERD, a potential surgical complication that has not been described. After frustrating medical treatment, the patient underwent computed tomography and nerve stimulator-guided blockade of vagal and phrenic nerves on each side separately. Hiccup seized only after blockade of the right phrenic nerve with 4 ml/h 1% ropivacaine and relapsed soon after discontinuation. He underwent thoracoscopic right phrenicectomy, which rendered him symptom free for well over 2 months, at the time of this writing.
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Tumor lysis syndrome following endoscopic radiofrequency interstitial thermal ablation of colorectal liver metastases

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Abstract
Radiofrequency interstitial thermal ablation (RITA) provides a palliative option for patients suffering from metastatic liver disease. This procedure can be performed using a laparoscopic approach with laparoscopic ultrasound used to position the RITA probe. We describe a case of laparoscopic RITA performed for colorectal liver metastasis that was complicated by tumor lysis syndrome (TLS) following treatment. We consider RITA to be a safe procedure, as supported by the literature, but where intracorporal tumor lysis is the treatment goal we believe that the systemic release of tumor products can overwhelm the excretory capacity; therefore, TLS is an inevitable consequence in some patients.
Key words: Radiofrequency interstitial thermal ablation — metastasis — tumor lysis syndrome
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A novel approach to gallbladder cancer in a Jehovah's Witness

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Abstract
Transfusion of blood or blood products peri- or postoperatively is often necessary in patients undergoing liver resections for hepatic or biliary tract neoplasms. In Jehovah's Witnesses this inevitably poses a difficult dilemma for clinicians. A 66-year-old female Jehovah's Witness with a T1b gallbladder cancer was referred to our specialist unit for further treatment after having had a routine laparoscopic cholecystectomy in another hospital. Although an abdominal computed tomography scan preoperatively showed a normal liver with no evidence of regional lymph node involvement, histologically the tumor was found in the posterior wall of the gallbladder adherent to the liver bed and had a full thickness involvement of the muscular layer, raising suspicion of a local invasion into the liver bed. The patient, having refused liver resection, was treated with a laparoscopic radiofrequency ablation under intraoperative ultrasound guidance using a newly developed "cooled-tip" needle and a 500-kHz radiofrequency generator. A "zone of necrosis" measuring 3.5 cm in diameter was created in the liver bed and adjacent tissues. The procedure lasted 90 min with no blood loss.