Case reports: Online First

Surg Endosc (2004) 18: 345–349
© Springer-Verlag New York Inc. 2003

SURGICAL ENDOSCOPY and Other Interventional Techniques

The full text versions of the abstracts presented here have been published online and are available for viewing at www.springerlink.com As a subscriber to *Surgical Endoscopy*, you have access to our SpringerLink electronic service, including Online First.

Retroperitoneal actinomycosis due to dropped gallstones

J. M. Ramia, A. Mansilla, J. Villar, K. Muffak, D. Garrote, J. A. Ferron
Hepatobiliary Unit, Department of Surgery, Hospital Universitario Virgen de las Nieves, Avda Fuerzas Armadas s/n, Granada 18014, Spain
Received: 25 June 2003/Accepted: 23 July 2003/
Online publication: 29 December 2003
DOI: 10.1007/s00464-003-4247-4
Abstract
Dropped bile and gallstones after accidental perforation of the biliary gallbladder is a frequent event during laparoscopic cholecystectomy and is generally of no clinical importance. However, calculi left in the abdominal cavity can produce a series of severe late complications. We present a patient with retroperitoneal actinomycosis produced by dropped gallstones after a laparoscopic cholecystectomy.
Key words: Laparoscopy — Cholecystectomy — Actinomicosis — Retroperitoneal — Gallstones
Correspondence to: J. M. Ramia

Situs inversus totalis

Giant hiatal hernia repair by laparoscopic Collis gastroplasty and Nissen fundoplication

C. D. Hoang,[1] Y. G. Bakman,[2] S. Ikramuddin,[3] M. A. Maddaus[1,3]
[1] Division of Cardiovascular and Thoracic Surgery, University of Minnesota Medical School, 420 Delaware Street SE, Minneapolis, MN 55455, USA
[2] University of Minnesota Medical School, Minneapolis, MN 55455, USA
[3] Section of Minimally Invasive Surgery, University of Minnesota Medical School, Minneapolis, MN 55455, USA
Received: 17 July 2003/Accepted: 28 July 2003/
Online publication: 31 December 2003
DOI: 10.1007/s00464-003-4510-8
Abstract
We report the repair of a giant hiatal hernia by laparoscopic Collis gastroplasty and Nissen fundoplication in a patient with situs inversus totalis, highlighting the unique anatomic challenges in this case. The 52-year old female patient had Kartagener's syndrome, a giant hiatal hernia, and a history of chronic severe gastroesophageal reflux disease with uncontrolled regurgitation. The laparoscopic procedure was accomplished with five ports placed in a mirror-image configuration, reversed from our standard positions. After visual confirmation of the complete reversal of the intraabdominal anatomy, we performed a modified Collis gastroplasty and Nissen fundoplication. Significant technical challenges were encountered intraoperatively. To the best of our knowledge, this report is the first of its kind in the literature. The use of advanced laparoscopic techniques is highly adaptable to unusual anatomy. Laparoscopic hiatal hernia surgery is feasible in patients with situs inversus.
Key words: Collis gastroplasty — Nissen fundoplication — Situs inversus — Kartagener's syndrome — Hiatal hernia — Laparoscopy
Correspondence to: M. A. Maddaus

Successful laparoscopic repair of a traumatic pubic symphysis hernia

A. Sharma,[1] P. K. Jain,[1] C. J. Shaw,[2] P. C. Sedman[1]
[1] Department of Upper GI and Minimally Invasive Surgery, Hull Royal Infirmary, Anlaby Road, Hull HU3 2JZ, United Kingdom
[2] Department of Orthopaedic Surgery, Hull Royal Infirmary, Anlaby Road, Hull HU3 2JZ, United Kingdom
Received: 27 June 2003/Accepted: 23 July 2003/
Online publication: 29 December 2003
DOI: 10.1007/s00464-003-4250-9
Abstract
A 48-year-old woman presented with a hernia through the center of her pubic symphysis 6 months after conservative treatment of an open-book fracture of the pelvis. This was repaired laparoscopically with a prosthetic mesh using a transperitoneal approach. Hernia through the pubic symphysis is a rare complication after traumatic symphysis diastasis, but repair using the laparoscopic approach is feasible and associated with rapid recovery from surgery.
Key words: Pubic symphysis — Hernia — Laparoscopy
Correspondence to: P. C. Sedman

source: https://doi.org/10.7892/boris.117549 | downloaded: 28.3.2024

Hand-assisted laparoscopic splenectomy for solitary splenic metastasis from uterine corpus carcinoma

H. Takahashi,[1,2] H. Yano,[2] T. Monden,[2] T. Kinoshita[1]
[1] Division of Hepatobiliary and Pancreatic Surgery, National Cancer Center Hospital East, 6-5-1, Kashiwanoha, Kashiwa, 277-8577 Chiba, Japan
[2] Department of Surgery, NTT West Osaka Hospital, 2-6-40, Karasugatsuji, Tennoji-ku, Osaka 543-8922, Japan
Received: 18 March 2003/Accepted: 29 July 2003/
Online publication: 29 December 2003
DOI: 10.1007/s00464-003-4509-1
Abstract
Solitary splenic metastasis is a rare condition. We performed hand-assisted laparoscopic splenectomy (HALS) for a solitary splenic metastasis from a uterine corpus carcinoma that had directly invaded the wall of the stomach. HALS is a superior technique that offers the advantages of both open and laparoscopic splenectomy, and it may become one of the options for the management of primary and secondary cancer of the spleen.
Key words: Endometrial adenocarcinoma — Splenic metastasis — Laparoscopic splenectomy — Cancer
Correspondence to: H. Takahashi

Bifocal esophageal and rectal cancer palliatively treated with argon plasma coagulation

R. Solecki, A. Zajac, P. Richter, M. Szura
First Department of General and GI Surgery, Jagiellonian University, 31-501 Krakow, Kopernika 40, Poland
Received: 29 April 2003/Accepted: 31 May 2003/
Online publication: 21 November 2003
DOI: 10.1007/s00464-003-4232-y
Abstract
Primary multiple neoplasms make a serious diagnostic and therapeutic problem. They occur infrequently; however, they must be considered in the diagnosis as the detection of simultaneous neoplastic foci requires change of therapeutic approach. We present a case of a patient with synchronous esophageal and rectal cancer treated at the Department of Surgery. Because of the advanced neoplastic process and concomitant diseases, the patient was qualified for minimally invasive procedures with recanalization using argon plasma coagulation to avoid injuring palliative procedures and to improve quality of life. The patient died of the primary disease without symptoms of gastrointestinal tract obstruction.
Key words: Multiple neoplasms — Rectal cancer — Esophageal cancer
Correspondence to: R. Solecki

Laparoscopic management following ultrasonographic-guided drainage in a patient with giant paraovarian cyst

A. S. Cevrioglu,[1] C. Polat,[2] V. Fenkci,[1] M. Yilmazer,[1] S. Yilmaz,[2] O. N. Dilek[2]
[1] Department of Obstetrics and Gynecology, Afyon Kocatepe University, School of Medicine, Afyon, Turkey
[2] Department of Surgery, Afyon Koeatepe University, School of Medicine, Afyon, Turkey
Received: 14 April 2003/Accepted: 7 May 2003/
Online publication: 21 November 2003
DOI: 10.1007/s00464-003-4226-9
Abstract
Background: Giant and paraovarian cysts are unusual masses that are usually treated by laparotomy. The safety of laparoscopic management of benign paraovarian cysts has been demonstrated, but it is believed that the size of benign paraovarian cysts is a limiting factor for laparoscopic surgery.
Methods: We describe a new technique for the laparoscopic removal of a giant and benign paraovarian cyst in a 40-year-old woman. A paraovarian cystic mass was detected on the right part of her body that extended to the liver. It was confirmed on both ultrasonography and computed tomography scans. After ultrasound-guided aspiration of the cyst, the mass was resected laparoscopically.
Results: No complications were noted during or after the surgical procedure. The patient was discharged on postoperative day 2.
Conclusions: Laparoscopic surgery can be safely applied in patients with giant and benign paraovarian cysts.
Key words: Paraovarian cyst — Laparoscopic surgery — Cyst drainage — Ultrasonography — Transabdominal drainage
Correspondence to: C. Polat

Dieulafoy-like lesion of the colon presenting with massive lower gastrointestinal bleeding

Successful endoscopic hemoclips application

P. Katsinelos, I. Pilpilidis, G. Paroutoglou, I. Galanis, P. Tsolkas, G. Fotiadis, P. Kapelidis, E. Georgiadou, S. Baltagiannis, S. Dimiropoulos, E. Kamperis, C. Koutras
Department of Endoscopy and Motility Unit, General Hospital "George Gennimatas,", Ethnikis Aminis 41, TK 546 35, Thessaloniki, Greece
Received: 17 April 2003/Accepted: 24 May 2003/
Online publication: 21 November 2003
DOI: 10.1007/s00464-003-4229-6
Abstract
The Dieulafoy's lesion is a rare cause of severe gastrointestinal hemorrhage. The lesion is usually located in the stomach, although it may occur anywhere in the gastrointestinal tract. It is characterized by severe bleeding from a minute submucosal arteriole that bleeds through a punctate erosion in an otherwise normal mucosa. We describe an elderly patient who presented with severe lower gastrointestinal bleeding caused by a colonic Dieulafoy-like lesion. This is the third report of colonic Dieulafoy's lesion treated successfully with endoscopic hemoclipping. We review the pathophysiology, clinical presentation, diagnosis, and treatment of this rare disease.
Key words: Dieulafoy's lesion — Colon hemorrhage — Endoscopic hemoclips application
Correspondence to: P. Katsinelos

Symptomatic cholecystolithiasis after laparoscopic cholecystectomy

S. Hellmig, S. Katsoulis, U. Fölsch
Klinik für Allgemeine Innere Medizin, Universitätsklinikum Schleswig-Holstein, Campus Kiel, Schittenhelmstr. 12, 24105 Kiel, Germany
Received: 29 April 2003/Accepted: 31 May 2003/
Online publication: 21 November 2003
DOI: 10.1007/s00464-003-4233-x
Abstract
A 45-year-old woman was admitted to our hospital complaining of upper abdominal pain. Seven months earlier a laparoscopic cholecystectomy had been carried out and a solitary gallstone removed together with the gallbladder. The patient now suffered from pain of the same character but lower intensity compared to the situation before the operation. At admission there were no abnormal laboratory findings, especially no signs of infection or cholestasis. Ultrasound revealed a stone in a gallbladder-like structure in the right epigastric region. ERCP revealed an inconspicuous cystic duct stump and no pathological findings in the extra- and intrahepatic bile ducts. MRCP and CT showed a cyst-like structure in the gallbladder region containing a concrement. The patient was transferred to the Department of Surgery for exploratory laparotomy, and a residual gallbladder with an infundibular gallstone was removed. The recurrent upper abdominal pain was obviously caused by a gallstone redeveloped after incomplete laparoscopic gallbladder resection. Retrospectively it could not be discerned whether a doubled or a septated gallbladder was the reason for the initial incomplete resection.
Key words: Laparoscopic cholecystectomy — Post-cholecystectomy syndrome — Biliary tract anomalies
Correspondence to: S. Hellmig

Endoscopic snare resection of an intrapapillary pedunculated villous adenoma presenting as acute recurrent pancreatitis

P. Katsinelos,[1] I. Pilpilids,[1] G. Paroutoglou,[1] P. Tsolkas,[1] R. Kotakidou,[2] K. Panagiotopoulou,[2] I. Galanis,[1] S. Dimiropoulos,[1] P. Kapelidis,[1] G. Fotiadis,[1] E. Georgiadou,[1] A. Iliadis[1]
[1] Department of Endoscopy and Motility Unit, Central Hospital, Ethnikis Aminis 41, TK 546 35, Thessaloniki, Greece
[2] Department of Istopathology, Central Hospital, Ethnikis Aminis 41, TK 546 35, Thessaloniki, Greece
Received: 16 May 2003/Accepted: 23 July 2003/
Online publication: 21 November 2003
DOI: 10.1007/s00464-003-4240-y
Abstract
Tumors of the papillary region are an unusual and heterogeneous group of neoplasms that arise from the major papilla, the ampulla of Vater, and the peripapillary duodenum. Benign adenomas of the papilla of Vater are an increasingly recognized condition in those with familial adenomatous polyposis syndromes as well as sporadic cases. Papillary adenoma is a recognized but rare cause of acute pancreatitis. We describe a patient who presented with acute recurrent pancreatitis that was attributed to an intrapapillary pedunculated villous adenoma. Following diagnosis by endoscopic needle knife sphincterotomy and endoscopic retrograde cholangiopancreatography, endoscopic snare resection of the adenoma resulted in symptomatic improvement.
Key words: Acute recurrent pancreatitis — Intrapapillary villous adenoma — Endoscopic snare resection — Endoscopic retrograde cholangiopancreatography
Correspondence to: P. Katsinelos

A rare life-threatening complication of migrated nitinol self-expanding metallic stent (Ultraflex)

H. S. S. Ho, H. S. Ong
Department of General Surgery, Singapore General Hospital, Outram Road, Singapore 169608, Singapore
Received: 25 June 2003/Accepted: 23 July 2003/
Online publication: 21 November 2003
DOI: 10.1007/s00464-003-4248-3
Abstract
The use of self-expanding metallic stents (SEMS) as esophageal endoprosthesis represents an advancement in the palliation of dysphagia from unresectable esophageal carcinoma. However, the problem of stent migration persists. Although most migrated stents have a benign outcome, complications do occur. Rare reports of intestinal obstruction have been confined to the stiff plastic and stainless-steel stents. We report the first case of intestinal obstruction secondary to the pliable Nitinol SEMS (Ultraflex) migration.
Key words: Migration — Nitinol SEMS self-expanding metallic stents — Intestinal obstruction
Correspondence to: H. S. Ong

Umbilical endometriosis

Another piece in the puzzle of the etiology of endometriosis

F. Frischknecht,[1] L. Raio,[2] A. Fleischmann,[3] E. Dreher,[2] K. P. Lüscher,[1] M. D. Mueller[2]
[1] Department of Obstetrics and Gynaecology, Kantonsspital Münsterlingen, 8596 Scherzingen, Switzerland
[2] Department of Obstetrics and Gynaecology, University of Bern, Effingerstrasse 102, Bern, Switzerland 3010
[3] Institute of Pathology, University of Bern, Effingerstrasse 102, Bern, Switzerland 3010
Received: 25 June 2003/Accepted: 23 July 2003/
Online publication: 29 December 2003
DOI: 10.1007/s00464-003-4245-6
Abstract
We report two women who presented with a recurrent, mildly painful, bluish nodule in the umbilicus. Both patients complained of local tenderness and occasional bleeding that increased during menstruation. Neither patient had had previous pelvic surgery. Excision of the lesions revealed a primary umbilical endometriosis; in one case, a simultaneous laparoscopy showed a pelvic endometriosis. We review the current literature and discuss the possible etiopathogenesis and when a

laparoscopy is indicated to diagnose a concomitant pelvic endometriosis. Umbilical endometriosis is a very rare disease but should be considered in the differential diagnosis of umbilical lesions.
Key words: Endometriosis — Umbilical — Etiopathology — Laparoscopy
Correspondence to: M. D. Mueller

Perforation of an ileostomy by a retained percutaneous endoscopic gastrostomy (PEG) tube bumper

T. R. Siegel, M. Douglass
Department of Surgery, The Mary Imogene Bassett Hospital, One Atwell Road, Cooperstown, NY 13326, USA
Received: 22 July 2003/Accepted: 28 July 2003/
Online publication: 29 December 2003
DOI: 10.1007/s00464-003-4505-5
Abstract
Percutaneous endoscopic gastrostomy (PEG) has become the procedure of choice for long-term enteral feeding. Complications are generally infrequent and often avoidable. We describe an unusual case in which a PEG tube bumper caused subcutaneous perforation of an ileostomy. After conservative treatment proved unsuccessful, revision of the ileostomy via a peristomal incision was performed, with good result. Caution must be exercised before considering the severance of a PEG tube at the skin, especially in patients with an ileostomy.
Key words: Percutaneous endoscopic gastrostomy (PEG) — Ileostomy — Perforation
Correspondence to: T. R. Siegel

Laparoscopic management of Chilaiditi's syndrome

C. E. Lohr,[1] M. A. Nuss,[1] D. W. McFadden,[2] J. P. Hogg[3]
[1] Department of Medicine, Robert C. Byrd Health Sciences Center, West Virginia University School of Medicine, PO BOX 9160, Morgantown, WV 26506, USA
[2] Department of Surgery, Robert C. Byrd Health Sciences Center, Post Office Box 92, Morgantown, WV 26506, USA
[3] Department of Radiology, Mary Babb Randolph Cancer Center, Post Office Box 92, Morgantown, WV 26506, USA
Received: 17 July 2003/Accepted: 28 July 2003/
Online publication: 29 December 2003
DOI: 10.1007/s00464-003-4506-4
Abstract
Chilaiditi's syndrome refers to the symptoms of abdominal pain, distention, vomiting, anorexia, and constipation caused by hepatodiaphragmatic interposition of the intestine. Although patients with this radiographic finding are commonly asymptomatic, presentation with symptoms is rare and accurately refers to this syndrome. There is an increased incidence of Chilaiditi's syndrome among mentally ill adults. Traditionally, Chilaiditi's syndrome is managed medically by discontinuing causative medicines. However, among the mentally ill population whose psychotropic medications precipitate the interposition of the colon, ceasing these psychotropic medications is not an appropriate option. The case presented involves a mentally ill patient with Chilaiditi's syndrome who was successfully managed with laparoscopic colopexy. At follow-up, the patient reported marked improvement of abdominal symptoms.
Key words: Chilaiditi's syndrome — Mental illness — Laparoscopic surgery — Colopexy
Correspondence to: M. A. Nuss

Primary endotracheal neurogenic tumors

Unusual airway tumors

S. Y. Low,[1] P. Eng,[1] A. Thirugnanam[2]
[1] Department of Respiratory and Critical Care Medicine, Singapore General Hospital, Outram Road, Singapore 169608, Singapore
[2] Department of Cardiothoracic Surgery, National Cancer Centre, Outram Road, Singapore 169608, Singapore
Received: 25 June 2003/Accepted: 23 July 2003/
Online publication: 29 December 2003
DOI: 10.1007/s00464-003-4246-5
Abstract
Benign tumors in the tracheobronchial tree are rare. We report two cases of primary endotracheal neurogenic tumors in patients who presented insidiously. Both patients did not manifest other clinical features of neurofibromatosis (Von Recklinghausen's disease). A single procedure using rigid bronchoscopy and neodymium: yttrium–aluminum–garnet laser resection resulted in excellent resolution of airway patency with good follow-up results in both cases.
Key words: Neurofibroma — Schwannoma — Endotracheal neurogenic tumor — Rigid bronchoscopy — Nd: YAG laser
Correspondence to: S. Y. Low

Laparoscopic gastric bypass after failed open horizontal stapled gastroplasty

S. D. St. Peter, J. M. Swain
Department of General Surgery, Mayo Clinic Scottsdale, 13400 East Shea Blvd, Scottsdale, AZ 85259, USA
Received: 5 March 2003/Accepted: 28 July 2003/
Online publication: 29 December 2003
DOI: 10.1007/s00464-003-4507-3
Abstract
The number of people in the population who have undergone an operative procedure for morbid obesity is likely to rise steadily as the awareness and popularity of bariatric surgery continues to develop. As this number increases, the number of patients with long-term failures and complications from these procedures will also rise. Although previous operations, particularly open procedures, normally deter surgeons from choosing a laparoscopic approach, the evolving technical skill of laparoscopic surgeons should allow for the reconsideration of these inhibitions. In this case, we present of laparoscopic Roux-en-Y gastric bypass on a 48-year-old woman who had undergone horizontal gastric stapling 20 years prior to presentation.

Key words: Gastric bypass — Reoperation — Laparoscopy — Gastroplasty
Correspondence to: J. M. Swain

Laparoscopic repair of various types of biliary-enteric fistula

Three cases

J. H. Lee,[1] H. S. Han,[2] S. K. Min,[1] H. K. Lee[1]
[1] Department of Surgery, Ewha Medical Research Center, Ewha Women's University College of Medicine, 911-1, Mok-dong, Yangcheon-gu, Seoul, 158-710 Korea
[2] Department of Surgery, Seoul National University College of Medicine, 28 Yongon-dong, chongno-gu, Seoul, 110-744 Korea
Received: 1 August 2003/Accepted: 8 September 2003/
Online publication: 29 December 2003
DOI: 10.1007/s00464-003-4514-4

Abstract
Biliary-enteric fistula is one of the reasons for converting from laparoscopic cholecystectomy (LC) to open surgery. Here we present three cases of various types of biliary-enteric fistula treated successfully by laparoscopic surgery. Two cases were diagnosed preoperatively, and the remaining case intraoperatively. The first patient had a cholecystoduodenal fistula with a common bile duct stone. The second patient had cholecystocolic and choledochoduodenal fistulas with a common bile duct stone, and the third patient had a cholecystogastric fistula. The fistulas were repaired laparoscopically by intracorporeal suturing or with an endoscopic linear stapling device. All the patients had good postoperative courses without any postoperative complication. Our experience has shown us that with advances in surgical skills and instruments, laparoscopic surgery for biliary-enteric fistula can be adopted as the first treatment choice regardless of the preoperative diagnosis.
Key words: Laparoscopic surgery — Biliary-enteric fistula
Correspondence to: H. S. Han