PPB24-001

REDUCED PORT SURGERY USING AN UMBILICAL ZIGZAG SKIN INCISION IN THE FIELD OF HEPATO-BILIARY-PANCREATIC SURGERY

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Introduction: Single-incision laparoscopic surgery or reduced port surgery is a rapidly progressing field as it offers some advantages such as cosmesis and less invasiveness. It is, however, technically demanding procedures due to its potential conflict of the surgical instruments. To address this issue, Hachisuka developed an idea of an umbilical Zigzag skin incision to hide the scar inside the umbilicus while securing enough working space. In this study, we describe our initial trial of an reduced port surgery through the umbilical Zigzag incision with favorable results.

Method: A total of 12 patients underwent reduced port surgery with this method: two partial hepatectomies, three distal pancreatectomies, and seven cholecystectomies. Zigzag shaped incision is established right on the umbilicus. Then, a GelPOINT double-ring wound retractor or Oval-shaped EZ access port was inserted through the incision, which enlarged the diameter of the fascial openings to 4–6 cm. Standard laparoscopic instruments were placed into the abdominal cavity. Once the laparoscope, grasper, and dissector are in place, the overall procedures are similar to the standard laparoscopic surgery.

Results: Single-incision laparoscopic surgery through an umbilical Zigzag skin incision was successfully completed in all 12 patients without conversion to open surgery. Additional trocars were inserted as necessary. Postoperative course was uneventful in all patients. On average, operative time was about 20% longer than that of conventional method. The blood loss, and the mean postoperative hospital stay were comparable to conventional procedures. No postoperative complications including seroma, wound infection, and trocar-site hernia were observed.

Conclusions: We described a new approach of reduced port surgery through umbilical Zigzag skin incision. We believe that this approach will widen the application of reduced port surgery in the field of hepato-biliary-pancreatic surgery by overcoming its technical difficulties, while maintaining cosmesis.

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ADJACENT VISCERA INVOLVEMENT IN GALLBLADDER CANCER: IS AGGRESSIVE RESECTION WORTHWHILE?

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Introduction: Involvement of extrahepatic adjacent organs in gall bladder cancer (GBC) is often considered as locoregionally advanced disease. While some consider it as a sign of inoperability, others perform an extended radical surgery (adjacent viscera resection including pancreatoduodenectomy) to achieve Ro resection.

Method: The prospectively collected database of GBC patients operated from May 2006 to September 2012 at our Centre was retrospectively analyzed. Patients with extrahepatic adjacent organ involvement requiring synchronous resection of involved viscera were analyzed to determine its impact on curative resection rate and extent of surgery.

Results: Of the 569 patients taken up for surgery 327 underwent curative resection. One hundred and thirteen patients required resection of one (n = 49) or more (n = 64) adjacent organs. Patients with gastroduodenal involvement without pancreatic involvement (n = 63) underwent duodenal sleeve resection for small area of contact (n = 27) or distal gastrectomy with proximal duodenectomy for wide area of contact (n = 36). Wedge resection of pancreas was performed in seven patients with minimal pancreatic involvement and hepatopancreatoduodenectomy in six patients for extensive pancreatic involvement or large retropancreatic nodes. CBD excision was performed in 75 patients for associated jaundice/bile duct involvement (n = 54), choledochal cyst (n = 12) or to facilitate lymph node clearance (n = 9). Colonic involvement (n = 33) required sleeve/segmental resection of colon in 25 patients and right hemicolectomy in 8 patients. Resection of single adjacent organ improved overall resectability from 37.60% (214/569) to 46.22% (263/569) and addition of more than one adjacent organ resection improved it to 57.47% (327/569).

Conclusions: Aggressive approach aimed at resection of involved adjacent viscera improves curative resection rate in GBC and survival. An R0 resection could be achieved with limited resection in most cases without a need for pancreatoduodenectomy.

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LAPAROSCOPIC CHOLECYSTO CHOLEDOCHOPLASTY IN MANAGEMENT OF TYPE II MIRIZZI SYNDROME – AN ANALYSIS

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Introduction: Mirizzi's syndrome is an uncommon cause of common hepatic duct obstruction resulting from gallstone impaction in the cystic duct or gallbladder neck with or with our cholecysto choledochal fistula. The management of Mirizzi's syndrome laparoscopically is a challenge. We did a retrospective analysis of all the type II Mirizzi's syndrome who were treated laparoscopically by cholecysto choledocho plasty

Method: During the period July 2000 to July 2012, 29 cases of Mirizzi syndrome were attempted to be operated laparoscopically. 7 patients of type II Mirizzi's syndrome were operated laparoscopically. An analysis of the operative technique adapted, complications and results of the laparoscopic cholecysto choledocho plasty were studied. All patients with suspected to be Mirizzi syndrome on pre operative ERCP and were stented. All were attempted laparoscopically. Gall bladder was opened at the Hartmann's pouch, the calculi were extracted, and the remnant gallbladder is fashioned into a flap and sutured to CBD. All the patients underwent a check cholangiogram after 4 weeks and stent removal.

Results: This study involved 7 cases of Mirizzi's syndrome of which 4 were men and 3 were women. One patient had post op bile leak which was managed conservatively and he improved. None of the patients had significant stricture on follow up period

Conclusions: Laparoscopic cholecysto choledochoplasty is a technically demanding procedure and can be safely performed in select centers in a sub group of patients however there should be low threshold for conversion to open whenever indicated even in experienced hands. Preoperative ERCP and stenting and a suspicion of Mirizzi's syndrome is helpful in the performance of the procedure

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AGENESIS OF GALLBLADDER-STILL AN INTRAOPERATIVE DIAGNOSIS

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Introduction: Gallbladder Agenesis is a rare entity and is still an intra operative diagnosis most of the times even in the era of advanced sonography. It was reported in the literature that up to 50% patients might have biliary symptoms even in the absence of gallbladder. The presence of biliary symptoms along with the falacies of ultrasonography may put the surgeons on per operative diagnostic dilemma.

Method: A 44 year old lady with right upper quadrant pain of 3 years duration and with history of attempted laparoscopic cholecystectomy elsewhere which was abandoned due to adhesions was referred to our hospital for further management

Results: She was reevaluated and Ultrasonography of Abdomen revealed features suggestive of chronic calculus cholecystitis. During laparoscopy after adhesiolysis of peri duodenal and portal adhesions gallbladder was not seen and the procedure was abandoned with a suspicion of gallbladder agenesis. It was confirmed by post operative Magnetic Resonance Cholangio Pancreatography (MRCP).

Conclusions: Gallbladder agenesis may not be as rare as it was thought previously .Surgeons should have high index of suspicion when gallbladder is not visible intraoperatively after reasonably adequate exposure of hilar and peri portal area. When there is a suspicion regarding this entity it is better to abandon the procedure to prevent biliary injury followed by a post operative MRCP to confirm the diagnosis.

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LAPAROSCOPIC SPLENECTOMY WITH CHOLECYSTECTOMY FOR TREATING HEREDITARY SPHEROCYTOSIS COMBINED WITH SYMPTOMATIC GALLSTONE

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Introduction: With the advancements that have been made in the field of minimally invasive surgery, combined laparoscopic procedures are now being performed for treating coexisting abdominal pathologies.

Method: We perform laparoscopic splenectomy with cholecystectomy at the same time to treat hereditary spherocytosis combined with symptomatic gallstone

Results: A 24-year-old woman presented with complaints of a new onset of abdominal pain. Abdominal CT scan evealed splenomegaly and several GB stones. Biochemical studies demonstrated anemia (hematocrit: 27% and hemoglobin: 9.7 g/dL) and hyperbilirubinemia (total bilirubin: 5.7 mg/dL). The diagnoses were confirmed by identifying the spherocytes on the peripheral blood smears, the increased reticulocyte counts, the increased osmotic fragility and negative Coomb's tests. We performed cholecystectomy and splenectomy via laparoscopic procedures. In case, an oral diet was resumed on the first postoperative day and She was discharged on the fifth postoperative day without any complications.

Conclusions: We have experienced good results of performing laparoscopic splenectomy and cholecystectomy at same time for treating hereditary spherocytosis that was combined with symptomatic gallstone