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Telesurgical laparoscopic cholecystectomy between two countries

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Abstract
Telesurgery is a form of operative videoconferencing in which a remotely located surgeon observes a procedure through a camera and provides visual and auditory feedback to the operative site. With the use of more robotic devices in laparoscopic surgery, various forms of telesurgery have been tried. We describe the first two international telesurgical, telementored, robot-assisted laparoscopic cholecystectomies performed in the world, between the Johns Hopkins Institute, Baltimore, Maryland, USA, and the National University Hospital, Singapore.
Key words: Laparoscopic cholecystectomy — Robotic — Telemedicine — Telementoring — Telesurgery
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Laparoscopic unroofing of retroperitoneal lymphoceles after bilateral retroperitoneal lymphadenectomy for testicular cancer

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Abstract
Background: Symptomatic lymphoceles after retroperitoneal lymphadenectomy for testicular cancer are a rare complication that can be managed by either a computed tomography (CT)-guided subcutaneous aspiration or surgery. One surgical method of choice is laparoscopic unroofing.
Methods: One case of two retroperitoneal lymphoceles managed by laparoscopy is presented. After successful creation of pneumoperitoneum, first trocar insertion, and lysis of adhesions, the two lymphoceles were unroofed, and specimens from the wall and fluid were taken.
Results: Laparoscopic surgery was uneventful, and the patient returned to activity and work within 14 days after the operation. No pathologic signs of malignancy were discovered during biopsy and cytology investigations. At the 1-month follow-up assessment, CT scan demonstrated the regression, and 1 year later the total absence of the lymphoceles.
Conclusions: After retroperitoneal lymphadenectomy for testicular cancer, clinical suspicion should remain high to detect and properly treat symptomatic lymphoceles. Large retroperitoneal lymphoceles can be treated effectively by unroofing under the safe direct vision of the laparoscope.
Key words: Laparoscopic unroofing — Lymphocele — Retroperitoneal lymphadenectomy
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Laparoscopically assisted treatment of acute abdomen in systemic lupus erythematosus

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Abstract
The incidence of abdominal pain in patients with systemic lupus erythematosus (SLE) is very high. Most patients do not require surgical treatment (serositis). Some cases such as appendicitis, perforated ulcer, cholecystitis or, rarely, intestinal infarction are surgical. Differential diagnosis is difficult, partly because noninvasive examinations do not provide enough evidence to rule out a diagnosis. On the other hand, in patients with SLE who have acute abdomen, it is dangerous to delay surgery by attempting conservative therapy. In fact, a better survival rate has been associated with early laparotomy. We report a case of acute abdomen in a patient affected by SLE, in which the diagnostic problem was solved by means of laparoscopy and the treatment was laparoscopically assisted. A 45-year-old woman with a 25-year history of SLE was admitted with abdominal pain and fever. Her physical examination revealed a painful right iliac fossa with rebound tenderness. Her WBC count was normal. Abdominal x-ray, ultrasonography, paracentesis, and peritoneal lavage did not provide a diagnosis. A diagnostic laparoscopy was performed, showing segmentary small bowel necrosis. The incision of the umbilical port site was enlarged to allow a small laparatomy, and a small