

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 intracorporeal 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 post-operatively 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.