Key words: Colectomy — Sigmoid colectomy — Diverticulitis — Situs inversus
Correspondence to: H. Davies

Emergency laparoscopic treatment for acute massive bleeding of an esophageal ulcer

C. Ballesta-López,[1] I. Poves,[1] C. Bettónica,[1] F. Fuertes,[1] J. C. Espinós[2]
[1] Teknon Medical Center, Surgical Laparoscopic Unit, Vilana 12, Consulta 148, 08022 Barcelona, Spain
[2] Teknon Medical Center, Digestive Endoscopic Unit, Vilana 12, 08022 Barcelona, Spain
Received: 29 April 2002/Accepted: 16 May 2002/Online publication: 29 October 2002
DOI: 10.1007/s00464-002-4230-5
Abstract
Laparoscopic fundoplication is now considered the treatment of choice for the management of severe gastroesophageal reflux disease (GERD) and its complications. The laparoscopic approach achieves the same good results as open surgery in elective surgery for GERD; it also has all the advantages of minimally invasive surgery. Today, laparoscopy plays also a significant role in a great variety of emergency abdominal situations and acute abdominal pain. A 30-year-old man was admitted to our center due to an upper gastrointestinal bleed caused by a esophageal ulcer over a Barrett's esophagus located in lower third of the esophagus. Two therapeutic esophagogastroscopies were done in 24 h, but urgent surgical intervention was indicated because of recurrent transfusion-demanding bleeding. A combined laparoscopic–endoscopic approach was followed. Surgery began with a complete hiatal dissection, including the distal third of the esophagus, diaphragmatic crus, and wide retrogastric window. Intraoperative flexible esophagoscopy revealed an active ulcer bleeding on the right anterior quadrant in the lower esophagus. Two transfixive stitches were applied through the wall of the esophagus at the site indicated by the light of the flexible endoscope, and complete hemostasis was achieved. Finally, employing the anterior wall of the fundus, a short Nissen-Rossetti fundoplication was performed. The operating time was 140 min. There were no complications and there has been no recurrence of the bleeding.
Key words: Esophageal ulcer — Emergency laparoscopic surgery — Barrett's esophagus — Upper gastrointestinal bleeding
Correspondence to: I. Poves

Unicornuate uterus and unilateral ovarian agenesis associated with pelvic kidney

B. Mülayim,[1] S. Demirbaşoğlu,[2] O. Oral[2]
[1] Obstetric and Gynecology Division, Baskent University, Alanya, Antalya, Turkey
[2] Obstetric and Gynecology Division, Zeynep Kamil Women and Children's Hospital, Üsküdar, Istanbul, Turkey
Received: 22 April 2002/Accepted: 16 May 2002/Online publication: 29 October 2002
DOI: 10.1007/s00464-002-4229-y
Abstract
In this report, we present a case of unilateral müllerian and ovarian agenesis associated with pelvic kidney. The patient was a 27-year-old woman who complained of an inability to conceive. We performed a hysterosalpingogram, hysteroscopy, laparoscopy, and an excretory urogram (IVP). At laparoscopy, we found an unicornuate uterus without a rudimentary horn. The right round ligament, fallopian tube, and ovary were present, but they were absent at the left side. Postoperative IVP revealed a pelvic kidney. Ultimately, her infertility was found to be due to a male factor: the abnormal semen of her partner. The couple was referred to our in vitro fertilization (IVF) unit. Because of the close embryologic association between the genital and urinary tracts, evaluation of the urinary tract in any patient with a genital or gonadal anomaly is necessary.
Key words: Unicornuate uterus — Pelvic kidney — Ovarian agenesis
Correspondence to: S. Demirbaşoğlu

Small bowel incarceration in a broad ligament defect

Successful laparoscopic management

P. Guillem,[1] C. Cordonnier,[1] F. Bounoua,[1] P. Adams,[2] G. Duval[1]
[1] Department of Surgery, Armentières Hospital, 112, rue Sadi Carnot, B.P. 189, 59421 Armentières Cedex, France
[2] Department of Radiology, Armentières Hospital, 112, rue Sadi Carnot, B.P. 189, 59421 Armentières Cedex, France
Received: 19 April 2002/Accepted: 16 May 2002/Online publication: 29 October 2002
DOI: 10.1007/s00464-002-4228-z
Abstract
We report the case of a 33-year-old woman whose medical history included three normal pregnancies without previous abdominal or pelvic surgery. She presented with small bowel obstruction. An abdominal computed tomography (CT) scan study revealed air fluid levels in the pelvis. Laparoscopic exploration revealed a viable ileal loop incarcerated through the mesoligamentum teres. The intestinal loop was reduced and the broad ligament defect was closed with a laparoscopic absorbable clip. Among internal hernias, hernias through a defect in the broad ligament represent only 4–7%. Defects within the broad ligament can be either congenital (ruptured cystic structures reminiscent of the mesonephric or mullerian ducts) or secondary to operative trauma, pregnancy and birth trauma, or prior pelvic inflammatory disease. CT scan may be diagnostic by showing incarceration of a dilated intestinal loop in the Douglas pouch with air fluid levels. This is the first reputed case of a totally laparoscopic repair of a bowel incarceration through a broad ligament defect.