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Abstract
We report a case of laparoscopic left lobectomy combined with right hemicolectomy for cystic liver tumor and hemorrhagic diverticulosis of the ascending colon. Mobilization of the right hemicolon was performed first with a complete laparoscopic method. Then the surgeon's left hand was inserted into the abdominal cavity through a 75-mm incision made in the right upper quadrant, and the hand-assisted method was used for completion after liver resection. After hepatectomy, the right hemicolon was pulled through the hand port incision. The resection and anastomosis were performed extracorporeally to avoid intra abdominal infection. As a hemihepatic inflow control technique, we used the method of *en masse* occlusion of Glisson's sheath of the left hemipedicle at the bifurcation. The hand facilitates proper traction and exposure of the cut surface, and hemostasis can be achieved by proper application of vascular clips or staplers. The patient had an uneventful, rapid postoperative recovery.
Key words: Laparoscopic surgery — Left lobectomy of the liver — Hemicolectomy — Hemihepatic vascular control technique — Hand-assisted method
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Spigelian hernia long considered as diverticulitis: CT scan diagnosis and laparoscopic treatment

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Abstract
Spigelian hernia (SH) develops in the spigelian aponeurosis. In some cases, its clinical symptoms may mimic those infrequently the diagnosis of sigmoid diverticulitis. Herein we report the case of a patient who for 12 years experienced a pain and a mass in the left lower quadrant that appeared after straining and then disappeared again after rest. A diagnosis of sigmoid diverticulitis was made. She was admitted to hospital for the acute onset of an intense abdominal pain in the left lower quadrant associated with fever. Physical exam showed a 10×15 cm mass in the left lower quadrant. Computed tomography (CT) scan showed a left-sided SH containing a small bowel loop and a sigmoid loop. The SH was reduced easily with bed rest and external pressure. Under laparoscopy, a Gore-Tex mesh was stapled on the posterior side of the anterolateral abdominal wall so that it widely covered the abdominal wall defect. The reducible SH, the incarcerated SH, and the strangulated SH represent the majority of the clinical aspects of SH. Although many differential diagnoses are proposed, but the diagnosis of sigmoid diverticulitis is an infrequent one. Ultrasound (US) scan or a CT scan that shows the defect in the abdominal wall, the hernial sac, and its contents is an easy means of confirming the diagnosis of SH. SH can be treated through a direct approach or through a midline laparotomy. Laparoscopy is advisable for a tension-free treatment with an intraperitoneal mesh. It is important to make the diagnosis of SH before its strangulation. For that reason, CT scan and US scan are highly recommended. Laparoscopic treatment, which is effective and safe, is advisable in such cases.
Key words: Spigelian hernia — Sigmoiditis — Laparoscopy
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Septic lithiasis of the pelvis

An unusual late complication of laparoscopic cholecystectomy

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Abstract
Laparoscopic cholecystectomy has become a standard technique for the treatment of symptomatic cholelithiasis. Despite a significant reduction in the complication rate with increasing experience, bile duct injury and gallstone spillage still occur more frequently with this approach than with the open procedure. Unretrieved gallstones, in particular, have been associated with late infection and the formation of abscesses in virtually every area of the abdominal cavity. We present a rare case of an isolated pelvic abscess that developed in a postmenopausal woman 5 months after laparoscopic cholecystectomy for recurrent cholecystitis. The preoperative differential diagnosis of this case is also discussed.
Key words: Laparoscopic cholecystectomy — Pelvic abscess — Ovarian torsion — Gallstones
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Laparoscopic body–tail pancreatic resection for insulinoma

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