discussed. The patient was found to have an unsymptomatic pneumoperitoneum on plain chest x-ray. The results of a contrast enema, computed tomography scan, and laparoscopy are presented. The patient had an uneventful hospital course without any specific therapy. Causes and possible therapeutic options are discussed.
Key words: Pneumoperitoneum — Pneumatosis cystoids intestinalis
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What happens to the lost gallstone during laparoscopic cholecystectomy?

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Abstract
Iatrogenic gallbladder perforation with resultant spillage of bile and gallstones is common during laparoscopic cholecystectomy. Although it's assumed to be harmless, several complications may occur as a result of spillage. We present a 57-year-old woman with localized abdominal pain in the upper abdomen, jaundice, and itching because of retained stones in both common bile duct (CBD) and the abdominal cavity, who had undergone laparscopic cholecystectomy three years previously. After reoperation, stones in the CBD were removed after CBD exploration and a T-tube was inserted. A mass (8×5 cm) located in the gastrocolic omentum, which was not reported on imaging studies, was found coincidentally and was totally excised. Investigation of the mass resulted in the discovery of eight gallstones located in the abcess-like central cavity, which was surrounded by fibrous tissue. The patient had an uneventful recovery. Despite the unaffected long-term sequelae, any patients with gallbladder perforations and spillage should not be considered for extension of antibiotic prophylaxis to avoid early complications. Whenever gallstones are lost in the abdominal cavity, every effort should be made to find and remove them to prevent late complications.
Key words: Laparoscopic cholecystectomy — Spillage — Complications — Retained stone
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Thoracoscopic treatment of a pericardial diverticulum

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Abstract
A 35-year-old female patient presented with a history of recurrent chest pain. On chest x-ray, a regularly shaped lesion at the right cardiophrenic angle was observed. The lesion appeared smaller on a subsequent x-ray. Magnetic resonance imaging showed a cystic lesion that could be differentiated from the pericardium only in its lower part. Thoracoscopy revealed a pericardial diverticulum. Resection of the lesion was performed thoracoscopically, with complete remission of the symptoms.
Key words: Pericardial diverticulum — Surgery — Thoracoscopy
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Needle-knife sphincterotomy

A safe and effective alternative endoscopic treatment for large choledochocele

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Abstract
Choledochocele, now classified as choledochal cyst type III, is a rare anomaly of the terminal biliary tree causing abdominal pain, pancreatitis, and obstructive cholestasis. Traditionally, the therapy for this malformation has been surgery. Recently, endoscopic therapy has been used alternatively for the treatment of choledochocele mainly in adults. We report two patients with recurrent episodes of acute pancreatitis found to be caused by a large choledochocele; both patients were treated by needle-knife sphincterotomy without complications. They remained asymptomatic at 1 and 2 years' follow-up, respectively. Despite the fact that the risk of bleeding seems to be higher using needle-knife sphincterotomy, when the Choledochocele is large, our experience suggests that needle-knife sphincterotomy can be performed accurately and safely. Further studies are necessary to confirm the safety and effectiveness of needle-knife sphincterotomy in large choledochocles.
Key words: Choledochocele — Needle-knife sphincterotomy — Acute recurrent pancreatitis
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Laparoscopic left hemihepatectomy combined with right hemicolectomy for liver tumor and hemorrhagic diverticulosis

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