Case reports: Online First

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Transvaginal extraction of the laparoscopically removed spleen

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Abstract
Laparoscopic removal of normal and moderately enlarged spleens has become the gold standard operation in recent years because its short operative time, technical safety, and quick patient recovery time. The best method for extraction of the removed spleen, however, has not yet been determined. The authors present a new method for the extraction of the laparoscopically removed spleen. Using a transvaginal approach, the organ is removed through an incision on the posterior vaginal wall and exteriorized in a laparobag. The procedure is similar to a routine vaginal hysterectomy, but is technically much simpler to perform.
Key words: Laparoscopic splenectomy — New method — Transvaginal
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Mesh penetration of the sigmoid colon following a transabdominal preperitoneal hernia repair

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Abstract
The laparascopic transabdominal preperitoneal (TAPP) repair of an inguinal hernia is an established technique associated with notably low rates of recurrence and complication. Inguinal pain and anal bleeding following a TAPP procedure may result from the penetration of the repair mesh into the sigmoid colon. In this case report, we discuss this particular complication following the TAPP procedure. Subsequently, we describe the diagnostics as well as the surgical treatment necessary.
Key words: TAPP — Mesh penetration — Diagnostics Surgical treatment
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An unusual cause of delayed presentation of laparoscopic common bile duct injury

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Abstract
We describe an unusual case of a laparoscopic common bile duct (CBD) injury that presented with cholangitis 2 years after an apparently uneventful laparoscopic cholecystectomy. Preoperative ultrasound and endoscopic retrograde cholangiography suggested choledocholithiasis, showing proximal and intrahepatic duct dilatation with an inability to relieve the obstruction. At surgery, a lateral injury of the CBD wall with partial wall loss was found, adherent to an amorphous pigmented mass with the appearance of a knitted fabric causing CBD obstruction. The CBD was successfully reconstructed with a Roux-en-Y end-to-side hepaticojejunostomy, where the end of the Roux loop was anastomosed to the lateral CBD defect.
Key words: Laparoscopic cholecystectomy — Common bile duct — Hemostatic agent
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Pneumatosis cystoides intestinalis coli

A rare differential diagnosis of pneumoperitoneum

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Abstract
The rare case of a 63-year-old male diagnosed with pneumatosis cystoides intestinalis coli is presented and

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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DOI: 10.1007/s00464-002-4242-1
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
Paper presented at the 9th International Congress of the European Association for Endoscopic Surgery, Maastricht, 2001
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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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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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Abstract
A case of pancreatic insulinoma with a neuroglycopenic syndrome was treated with laparoscopic body–tail pancreatic resection. An en bloc splenectomy was required due to the close anatomic relation of the insulinoma with the splenic vein, as shown on intraoperative ultrasonography. The operative time was 4 h, and blood loss was minimal (<200 ml). Laparoscopic coagulating shears were used for the pancreatic mobilization, and an endoGIA was used for the section of the splenic vessels and the central pancreatic transection. The postoperative course was uneventful, and the patient was discharged in good condition on the 7th postoperative day. We concluded that laparoscopic access in patients with pancreatic disease is not only a valuable way to establish or confirm a diagnosis and assess the severity of the disease but also a safe way to perform distal pancreatic resection.
Key words: Laparoscopy — Pancreas — Insulinoma — Laparoscopic ultrasonography — Laparoscopic pancreatic resection
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Laparoscopic cholecystectomy in a patient with previous open cholecystostomy

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Abstract
We report the case of a successful elective interval laparoscopic cholecystectomy in a patient with a previous tube cholecystostomy that had been performed surgically 8 weeks earlier for an attack of acute calculous cholecystitis. At surgery, the major omentum was adherent to the right lateral abdominal wall, completely covering the liver edge, the gallbladder, and the inserted tube. The gallbladder and the tube within it were dissected free from the abdominal wall and the greater omentum, the cholecystostomy tube was removed, and the operation was completed successfully without any further difficulties.
Key words: Cholecystectomy — Laparoscopic cholecystectomy — Open cholecystostomy — Tube cholecystostomy — Gallbladder
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Laparoscopic-assisted resection of giant sigmoid lipoma under colonoscopic guidance

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Abstract
Colonic lipomata are rare and mostly asymptomatic lesions; but as they become larger they may produce abdominal pain, constipation, diarrhea, hemorrhage, and intussusception. We report the case of a 75-year-old man who suffered from nonspecific recurrent abdominal pain in the left upper and lower quadrants and had variable episodes of diarrhea and constipation of 4 weeks' duration. During colonoscopy, a giant intraluminal polyp was diagnosed at 35 cm. Abdominal helical computed tomography (CT) revealed a constipating colonic tumor with a diameter of ≥50 mm and density values equal to fat. During laparoscopic surgery in the lithotomy position, the sigmoid and the descending colon were mobilized using a Harmonic scalpel. The origin of the polyp was localized precisely under colonoscopic guidance. The former 12-mm incision in the left lower quadrant was expanded to ~70 mm for extracorporal tumor resection. The left and sigmoid colon resections were carried out, and the polyp was removed by full-wall excision. After closure with a single-layer suture, the colon was pushed back into the peritoneal cavity. The patient had an uneventful recovery and was discharged 10 days postoperatively. Histology confirmed a benign lipoma of the descending colon. Laparoscopic-assisted resection under endoscopic guidance proved to be suitable for the removal of large colonic polyps without complications.
Key words: Lipoma — Colonoscopy — Laparoscopy — Intussusception
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Laparoscopic sigmoid colectomy for diverticular disease in a patient with situs inversus

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Abstract
We present the case of a 50-year-old man with situs inversus who underwent laprascopic colonic resection for diverticulitis. The patient, who had right-sided pain due to inversion of the viscera mimicking appendicitis, initially presented a diagnostic challenge. A barium meal confirmed situs inversus and the diagnosis of diverticulitis. We present an overview of the operative technique of what is the first documented laparoscopic colectemy in a patient with situs inversus. We then discuss the benefits of the laproscopic approach to colectomy, with reference to this interesting case with unusual anatomy.

Key words: Colectomy — Sigmoid colectomy — Diverticulitis — Situs inversus
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Emergency laparoscopic treatment for acute massive bleeding of an esophageal ulcer

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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
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Unicornuate uterus and unilateral ovarian agenesis associated with pelvic kidney

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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
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Small bowel incarceration in a broad ligament defect

Successful laparoscopic management

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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.

Key words: Small bowel — Intestinal obstruction — Broad ligament — Laparoscopy
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Acute recurrent pancreatitis associated with anomalous pancreaticobiliary ductal union and choledochal cyst of mixed type I plus II

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Abstract
Anomalous pancreatobiliary ductal union (APBDU) has a variety of presentations. We report the case of a 72-year-old woman who presented with recurrent episodes of acute pancreatitis that were found to be caused by the presence of an APBDU associated with an unusual choledochal cyst of mixed type I plus II. She underwent endoscopic sphincterotomy and has remained asymptomatic to the present time, 2 years after sphincterotomy. A discussion of the possible etiologies of choledochal cyst and pancreatitis due to APBDU is presented.
Key words: Anomalous pancreatobiliary ductal union (APBDU) — Choledochal cyst — Acute recurrent pancreatitis — Pancreas — Common bile duct
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Thoracoscopic repair of a Bochdalek hernia in an adult

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Abstract
Bochdalek hernia is a rare congenital diaphragmatic hernia in adults. In most cases, there are no symptoms. Rarely, it requires surgical intervention. In cases with pain or visceral strangulation, laparatomy or laparoscopy are both possible. We present the case of an adult with a Bochdalek hernia. He was operated on via a thoracoscopic approach and had an uneventful recovery. We recommend the thoracoscopic approach as an alternative to open or laparoscopic approach in cases of noncomplicated Bochdalek's hernia.
Key words: Bochdalek hernia — Thoracoscopic repair — Hernia — Diaphragmatic hernia
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Laparoscopic right posterior hepatic bisegmentectomy (Segments VII–VIII)

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Abstract
The role of laparoscopy in liver surgery is still a subject of debate. Up to now, isolated hepatic lesions requiring a segmental (or bisegmental) resection have been considered to be an indication for laparoscopic surgery only when they are located in the left lobe or in the right lower lobe, whereas an open approach by laparotomy or thoracotomy is still preferred for lesions of the upper right lobe. Here we report a case of a right posterior hepatic bisegmentectomy (segments VII—VIII) performed for a hepatic hemangioma that was carried out entirely laparoscopically. In our opinion, there is not an a priori contraindication to the laparoscopic resection of any hepatic benign lesion, wherever it is located in the liver parenchyma. Nevertheless, major hepatic resections still have to be performed by expert surgeons in specialized centers.
Key words: Laparoscopy — Liver — Hepatic hemangioma — bisegmentectomy — Resection — Harmonic scalpel
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Percutaneous cholecystostomy with locking trocar: how I do it?

A case report

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Abstract
Cholecystectomy and open cholecystostomy are associated with a high mortality rate in critically ill patients. Ultrasound-guided percutaneous cholecystostomy has a high success rate with few complications. The following method of percutaneous cholecystostomy with locking trocar (LT) under direct laparoscopic vision is seen to be an effective, safe, and practical procedure. After the abdomen is prepared from xiphisternum to symphysis pubis, the umbilicus and surrounding skin are infiltrated with 1% combined lignocaine and adrenaline. A 10-mm laparoscopy trocar is inserted via a 10-mm subumbilical incision. After a camera is inserted via the trocar, the abdomen and gallbladder are exposed. The skin of the geometric projection of fundus is infiltrated with the same solution, and a 5-mm LT is introduced via a 5-mm skin incision directed to the fundus of the gallbladder

guided by the direct view of a laparoscope. When the LT has penetrated to the gallbladder, the bile and contents of the gallbladder are aspirated immediately to reduce the pressure, and the trocar is locked. The locked trocar is fixed to the abdominal wall under traction until the completion of peritonization to prevent bile leakage. The gallstones can be extracted through the trocar by a laparoscopy forceps. This technique was used for a 75-year-old woman with calculous cholecystitis and cardiopulmonary insufficiency, and her progress at this writing is good.

Key words: Percutaneous cholecystostomy — Locking trocar — Laparoscopy

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