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SURGICAL TREATMENT OF SPONTANEOUS EXTRAPLEURAL HAEMORRHAGE AND PULMONARY HERNIA: A CASE REPORT

N.P. ARDO'[1], D. LOIZZI[1], G. PACELLA[2], F. CIALDELLA[2], F. SOLLITTO[1]

[1] Dip. Scienze Mediche e Chirurgiche, Sezione e S.C. Chirurgia Toracica, Università di Foggia, Ospedali Riuniti di Foggia, Foggia, Italia; [2] Dip. Emergenze e Trapianti d'Organo, Sezione e U.O. Chirurgia Toracica, Università degli Studi di Bari "A. Moro", Ospedale Policlinico di Bari, Bari, Italia

Objective: A case of spontaneous extrapleural haemorrhage and pulmonary hernia in a overweight 66-year old man is described. The event occurred 4 months after the developing of a thoracoabdominal wall haemathoma. Both episodes followed severe coughing during acute exacerbation of chronic bronchitis.
Methods: A 66-year old man with BMI 44.6, history of chronic lymphocytic leukemia and hypertension was admitted to the emergency department for severe chest pain. He referred cough for three weeks. A chest CT revealed a thoracoabdominal wall haemathoma and an irregular lung profile mimicking a slight right pulmonary hernia. No invasive procedures were performed.
Three months after discharge, he returned to hospital for similar symptoms and chest X-rays revealed the onset of a pleural opacity in the right hemithorax. A chest CT confirmed the pulmonary hernia, which was significantly increased in dimensions, and showed the presence of an extrapleural haemorrhage with fracture of the seventh right rib. The patient was admitted to the Thoracic Surgery departement and the following chest X-rays disclosed the progressive extension of the haemorrhage. Hemoglobin levels declined during the hospital stay from 15.1 to 9.5 g/dL. A posterolateral thoracotomy was performed showing a pulmonary hernia next to the rib fracture and intra-/extra-pleural haemorrhage without signs of active bleeding. The thoracic wall was fixed by rib sutures.
Results: The post-operative stay was free from complications and the patient was discharged on the seventh post-operative day. The sixth-month clinical and radiological check shows no further episodes of active bleeding nor pulmonary hernia relapse. The patient still refers sporadic, mild chest pain.
Conclusions: Recurrent spontaneous extrapleural haemorrhage and pulmonary hernia after severe coughing is a rare observation. According to our examinations, this case is probably related to the patient's obesity and to repeated fits of coughing during acute exacerbation of chronic bronchitis which lead to rib fracture and the following pulmonary hernia with haemorrhage. After surgery the clinical manifestations improve immediately, thus the surgical reduction of the fracture is highly recommended.

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RESULTS OF POST-TRAUMATIC CHEST WALL STABILIZATION FIVE YEARS AFTER THE INTRODUCTION OF A NEW TITANIUM PLATES SYSTEM

F. DI GENNARO[1], A. DE PALMA[1], M. LORUSSO[1], D. SCARASCIA[1], M. BITETTO[1], F. SOLLITTO[2], M. LOIZZI[1]

[1] Sezione di Chirurgia Toracica, Università degli Studi di Bari "Aldo Moro", Bari, Italia
[2] Sezione di Chirurgia Toracica, Università degli Studi di Foggia, Foggia, Italia

Objective: The protection of endothoracic organs and an adequate respiratory function are ensured by chest wall integrity and stability. We report our experience with a new titanium plates system, introduced about five years ago, to repair traumatic injuries of the chest wall.
Methods: From January 2010 to May 2014, 11 male patients, median age 61 years (range: 16-75 years), were treated at our Institutions with a new titanium plates and splints system (Synthes®) for post-traumatic ribs and sternum stabilization. Indications were as follows: flail chest (5), multiple ribs fractures (5), posterior sternoclavicular joint dislocation (1). All patients underwent pre-operative chest wall tri-dimensional CT study to precisely evaluate the site and the entity of the traumatic injuries.
Results: From 1 to 10 (median 3) titanium plates and/or splints were implanted in each patient. Median operating time was 130 minutes (range: 115-240 minutes), without intra-operative complications. One patient with significant co-morbidities required post-operative tracheostomy. Median post-operative ICU stay was 3 days (range: 0-29 days), hospital stay 26 days (range: 7-61 days). No post-operative mortality occurred. Seven patients (64%) had no post-operative complications; minor complications occurred in three (27%); major complication in one (9%). At a median follow-up of 18 months, no post-traumatic deformity and respiratory deficit were present. Long-term results in terms of quality of life have been evaluated with SF 12 standard V1 questionnaire: 62,5% of patients reported a general good condition of life, with no pain, 25% excellent, 12,5% acceptable.
Conclusions: The new titanium plates system allowed to obtain an optimal post-traumatic stabilization of the chest wall, with restoration of a normal respiratory function and a significant reduction of post-traumatic pain, deformity and need for mechanical ventilation.

CRITICAL APPRESIAL OF THE USE OF ENDOPROSTHESIS IN THE MANAGEMENT OF BARIATRIC SURGERY COMPLICATIONS

A. IOSSA, F. DE ANGELIS, O. IORIO, M. RIZZELLO, G. CAVALLARO, M. AVALLONE, S. RUSCIO, F. LONGO, G. SILECCHIA

Divisione di Chirurgia Generale e Bariatric Centre of Excellence - ICOT, Università "Sapienza", Latina, Italia

Introduction: The management of upper gastrointestinal anastomotic complications is complex and challenging especially in morbid obese population. Treatment of upper gastrointestinal complications, such as leaks and strictures, using endoscopic covered self-expandable metal stents (SEMS) is emerging as a safe and effective alternative especially in case of early postoperative leak. The benefits of endoscopic approach in the management of compromised high-risk morbid obese patients have been extensively mentioned by several authors.
Aim: to report three cases of unusually severe adverse events related to endoprosthesis used for non-surgical management of post-bariatric surgery complications
Case 1: A 41 years old men with GERD "de novo" and weight regain after sleeve gastrectomy (SG) with the concomitant presence of "neofundus" submitted to fundectomy. The procedure was complicated by a leak in 10 p.o. days. After 30 days of un-succesfully conservative management we proceed to stent positioning, there will be compounded by esophageal stenosis reflux-related.
Case 2: A 39 years old female affected by II Grade obesity, GERD and class C esophagitis submitted to Gastric By Pass (GBP). We diagnosed, 25 days after operation, an anastomotic stricture that was treated with endoscopic dilation. The second dilation was made worse by anastomotic perforation treated with stent implanting. 8 days after their implant the patient required a laparoscopy urgent stent-removal for ileal migration.
Case 3: A 57 years old female submitted in 2004 to Vertical Gastroplasty sec Mason affected by weight regain, gastro-gastric fistula related, and severe GERD. Submitted to GBP conversion, she developed an anastomotic leak treated conservatively for over 35 days, un-succesfully. We have decided to position endoscopic stent that after 8 days migrated requiring endoscopic repositioning, and 10 days after was complicated by esophago-right pleural leak.
Conclusions: Three severe unusual complications of endoscopic stent used for the treatment of Bariatric complications are reported. Bariatric surgeons have to balance case by case the possible advantages vs disadvantages of endoscopic management of stenosis and leak after laparoscopy bariatric procedures.

PREVALENCE OF GASTROINTESTINAL SYMPTOMS AND UPPER ENDOSCOPIC FINDINGS IN A POPULATION OF OBESE PATIENTS CANDIDATE TO BARIATRIC SURGERY: A PROSPECTIVE STUDY

M. AVALLONE[1], M. CARABOTTI[2], A. LIGUORI[1], M. RIDOLFI[2], F. LONGO[1], S. RUSCIO[1], D. CAPOCCIA[3], A. SCIROCCO[2], F. LEONETTI[3], C. SEVERI[2], G. SILECCHIA[1]

[1] Department of Medical Surgical Sciences and Biotechnology, "Sapienza" University, Rome, Italia
[2] Department of Internal Medicine and Medical Specialties, "Sapienza" University, Rome, Italia
[3] Department of Experimental Medicine, "Sapienza" University, Rome, Italia

Objective: International guidelines recommend to perform a preoperatory multiple biopsy esophagogastroduodenoscopy (EGDS) only in symptomatic patients candidate to bariatric surgery. The aim of this prospective study is to assess if upper gastrointestinal symptoms can be considered a reliable tool to indicate a preoperatory EGDS to diagnose mucosal injuries or anatomic alterations. Surgical outcomes are based on these alterations.
Methods: 130 consecutive obese patients candidate to bariatric surgery filled in the "Roma III modular symptomatic questionnaire" before surgery; this schedule asked about upper gastrointestinal symptoms seriousness. After that, all patients underwent to multiple biopsy EGDS. A multivariate analysis about these parameters was performed: sex, BMI, Symptoms score, HP, hiatal hernia, esophagitis.
Results: Asymptomatic patients were 43 % but endoscopic findings was discovered in 35% (20 patients) of this group: 5.3 % of patients were positive for erosive esophagitis, sliding hiatal hernia was found in 14.3 %, erosive gastroduodenitis (10.7%), peptic ulcer (1.7%), the H. Pylori infection prevalence was 19.7 %. Symptomatic patients were 57 % but only 43 % (32 patients) were positive for endosopic findings: erosive esophagitis (8.1 %), sliding hiatal hernia (12.2 %), erosive gastroduodenitis (8.1 %), peptic ulcer (2.7 %), H. P. infection was found in 21.6 %.
Conclusions: The results of this prospective study confirms the higher prevalence of upper gastrointestinal symptoms in morbid obese patients than in the general population upper gastrointestinal symptoms cannot be considered as a reliable tool to indicate esophagogastroduodenoscopy, since the endoscopic lesions are equally distributed in asymptomatic and symptomatic patients. Routine preoperative endoscopy should be considered. it can be hypothesized a possible pathogenic role of systemic inflammation in the development of hp-negative peptic lesions.

RESIDUAL FUNDUS OR NEOFUNDUS AFTER LAPAROSCOPIC SLEEVE GASTRECTOMY: IS FUNDECTOMY SAFE AND EFFECTIVE AS REVISION SURGERY?

F. DE ANGELIS, A. IOSSA, O. IORIO, M. AVALLONE, G. PATTARO, S. RUSCIO, G. CAVALLARO, M. RIZZELLO, G. SILECCHIA

Division of General Surgery & Bariatric Center of Excellence, Department of Medico-Surgical Sciences and Biotechnology, Hospital ICOT, "Sapienza" Università di Roma, Latina, Italia

Objective: Up to 30% of patients who have undergone Laparoscopic Sleeve Gastrectomy (LSG) require revision surgery for inadequate weight loss, weight regain and/or the development of severe upper gastrointestinal (GI) symptoms . The aim of this retrospective study was to evaluate the safety and efficacy of laparoscopic fundectomy (LF) in cases of a residual fundus/ neofundus development with respect to GERD symptoms.
Methods: The study group comprised 19 patients (17 female; mean BMI 35.4 kg/m^2) divided into 2 groups. Group A (n =10) patients with severe GERD and evidence of residual fundus,/neofundus, Hiatal Hernia (HH) with good results in terms of weight loss. Group B (n = 9) patients with severe GERD, a residual fundus/ neofundus, inadequate weight loss or weight regain. Fundectomy was indicated when a residual fundus/neofundus was associated with severe GERD symptoms. The presence of a residual fundus/ neofundus was assessed by a barium swallow and/or multislice computed tomography.
Results: No mortality or intraoperative complications occurred. Five postoperative complications occurred: 2 cases of bleeding , 1 midgastric stenosis and 2 leaks (10.5%). All patients experienced improvements in their GERD symptoms and stopped PPI treatment. Group B exhibited an additional %EWL of 53.4% at 24 months.
Conclusions: LF and cruroplasty is feasible and has good results in terms of GERD symptoms control and additional weight loss. The high rate of postoperative complications observed in this series remains a matter of concern. A re-sleeve procedure might be considered as an alternative to RYGB/DS conversion restricted to select patients.

LAPAROSCOPIC SLEEVE GASTRECTOMY AS REVISIONAL PROCEDURE FOR FAILED LAPAROSCOPIC GASTRIC BANDING WITH A "TWO-STEP APPROACH"

F. DE ANGELIS, O. IORIO, A. IOSSA, M. AVALLONE, G. PATTARO, F. LONGO, S. RUSCIO, G. CAVALLARO, M. RIZZELLO, G. SILECCHIA

Division of General Surgery & Bariatric Center of Excellence, Department of Medico-Surgical Sciences and Biotechnology, Hospital ICOT, "Sapienza" Università di Roma, Latina, Italia

Objective: Recently laparoscopic sleeve gastrectomy (LSG) has been proposed as an alternative revisional procedure for failed and/or complicated adjustable gastric banding. The study is a retrospective review of a prospectively maintained, multicentric, database of revisional LSG performed weeks after laparoscopic band removal for insufficient weight loss/weight regain and/or band-related major complications ('two step approach'). Indications for revisional surgery, Body Mass Index (BMI kg/m^2), % Excess Weight Loss (EWL) (24 months follow up), duration of the first and second procedure, length of postoperative hospital stay, intraoperative and perioperative complications were reviewed and compared to those of a concurrent series submitted to LSG as primary procedure (control group).
Methods: From January 2008 to December 2011, 76 two-step revisional LSG were recorded; a control group of 279 non-revisional (primary) LSG, performed in the same interval period has been selected. The primary end point was to compare the perioperative complications rate between two-step revisional vs control group. Secondary endpoints were operative time, intraoperative complications, conversion to open surgery, postoperative hospital stay and weight modifications (%EWL) at 6, 12 and 24 months.
Results: The two groups (revisional LSG and primary LSG) did not differ significantly in terms of age, gender, BMI and co-morbidities. The indications for band removal were; insufficient weight loss in 47 patients, band slippage in 10 patients, band erosion in 7 patients and pouch dilatation in 12 patients. All procedure were completed laparoscopically. The mean LSG operative time was 78 minutes for revisional and 65 minutes for primary ($p<0.05$). In revisional LSG group, the overall complications rate was 17.1%, and the mean postoperative hospital stay was 4 days vs 10.7%, and 3 days in the control group. No complications requiring reoperation or readmission were registered in the two step revisional group. The mortality was nil in both group. In the control group, 5 cases of major complications were registered. Fifty-six patients of the revisional group and 184 patients of the control group completed 24 months follow-up. At 6,12 and 24 months the %EWL was 46.5%, 66.4 % and 78.5% in revisional group and 49.8%, 78.2%, 78% in the control group.
Conclusions: Our results confirmed that LSG is a safe and effective revisional procedure for failed or complicated LAGB with good perioperative outcomes and 2 years weight loss.

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BOWEL OBSTRUCTION DUE TO ILEAL VOLVULUS AND GASTRIC DIASTATIC PERFORATION WITH MIGRATION OF INTRAGASTRIC DEVICE FOR GASTRIC BANDING

M. GIUSSANI, F. CANTORE, P. MOGLIA, M. ABUAWWAD, D. LOVOTTI, A. PIERINI, R. MACCHI, P.G. CAPRETTI

Azienda Ospedaliera Sant'Anna, Como, Italia

Objective: Gastric banding is a method for the long-term control of the weight loss. The laparoscopic adjustable gastric banding (LAGB) is the most commonly used procedure in Europe. Below we report the case of a rare complication, occurring after 13 years of LAGB placement (laparoscopic adjustable gastric band), expressed itself as a mechanical bowel obstruction.
Methods: Patients: The patient, 34 years of age, comes to our attention for repeated episodes of vomiting food and diffuse abdominal pain. After examination is hyperamylasaemia with increased CRP, not leukocytosis, ARF. At TC subocclusion with gastrectasia. We indicate to undergo with surgery on the basis of clinical and instrumental deterioration. We located bowel obstruction from internal hernia with peritonitis of the distal jejunum loop tract intraperitoneal tube device with perforation of the small intestine at the level of the strangle loop and, as a complication associated stomach perforation on the lesser curvature of the device and further drilling, diastatic , on the great curve of the body. The removal of the bandage with release internal hernia, segmental resection of jejune and suture gastric perforations. Entero-entero anastomosis latero-lateral anisoperistaltic mechanics. Lysis of adhesions.
Results: erosion and migration of gastric banding complications are rare, and usually not life-threatening. The small bowel obstruction due to an internal hernia reflect a greater emergency. Usually occurs after gastric bypass or biliopancreatic diversion, in our case, is due to the formation of a loop of the tube intraperitoneal, after LAGB. The proper diagnosis and immediate treatment are mandatory.
Conclusions: Bariatric surgery has presented a large increase, therefore the general surgeon must be familiar with the most common bariatric procedures, and know how to manage their complications as other gastrointestinal surgical procedures.

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OPEN REPAIR VERSUS ENDOVASCULAR TREATMENT FOR POPLITEAL ARTERY ANEURYSMS: RESULTS OF A RETROSPECTIVE STUDY IN A SINGLE CENTRE

S. COLLURA[1], E. CERVI[1], P. BAGGI[1], M. DE LUCIA[1], R. MAFFEIS[1], G. BATTAGLIA[2]

[1] Chirurgia Vascolare (Prof. S. Bonardelli) - Clinica Chirurgica, Università degli Studi di Brescia, Brescia, Italia
[2] Istituto di Radiologia II (Prof. R. Maroldi), Università degli Studi di Brescia, Brescia, Italia

Objective: To compare the outcomes of the endovascular treatment of popliteal artery aneurysms (PAA) with the outcomes of the open repair especially in terms of primary patency, secondary patency and rescue of the limb.
Methods: A series of 44 patients (a total of 49 PAA) was treated in our hospital between January 2010 and May 2014. 20 aneurysms were treated with surgery (group 1). 18 out of 20 cases underwent substitution with PTFE prosthesis. 29 aneurysms underwent endovascular treatment (group 2). There were no statistically significant differences between the 2 groups in terms of risk factors (hypertension, dyslipidemia, diabetes, smoking) or presence of symptoms.
Results: In the first group the primary patency was 100%, 100%, 88,8% and 85,7% at 1, 3, 6 and 12 months respectively, whereas in the second group it was 90%, 89,3%, 84% and 86% respectively without any statistically significant difference (log-rank test). In both groups the secondary patency was 100%. No deaths were recorded and there was only one major limb amputation (open surgery).
Conclusions: Nowadays the open way is still the gold standard for the treatment of PAA and we have few data about long term outcomes of the endovascular treatment. Nevertheless the improvements made in this latter, the outcomes in terms of patency and rescue of the limb and some evident advantages (minimal loss of blood, shorter hospital stay) make endovascular treatment really interesting and promising. However endovascular treatment shouldn't involve tibio-peroneal trunk precluding the possibility to perform secondary open surgery.

THORACO-ABDOMINAL TYPE IV AND BILATERAL ILIAC ANEURYSM EXCLUSION WITH A FENESTRATED ENDOGRAFT AND BILATERAL ILIAC SIDEBRANCH

M. BARBANTE

Chirurgia Vascolare, Policlinico Tor Vergata - Università Degli Studi Di Roma Tor Vergata, Roma, Italia

Objective: To describe an advanced and innovative endovascular technique for repair of complex aortic thoracoabdominal and iliac aneurysms.
Methods: Male, 72 years, affected by coronary artery disease, hypertension, dyslipidemia, obesity (BMI: 36) and active smoker, come to our institution with a CTA diagnosis of an large asymptomatic type IV thoracoabdominal aortic aneurysm of 60 mm, and bilateral common iliac arteries aneurysm, right side 60 mm and left side 45 mm. Surgical repair was excluded for high risk patient with multiple comorbidities, and then we evaluate the endovascular option. Our problem in preoperative planning was the management of proximal sealing and iliac arteries; the options was to perform a chimney technique on visceral vessels with standard aortic endograft or custom made fenestrated aortic endograft, and branching or exclusion of hypogastric arteries. We have considered the risk of pelvic ischemia consequent to bilateral or unilateral hypogastric exclusion, and the lack of urgency/emergency repair in asymptomatic patient. Therefore we have decided to proceed with a custom-made fenestrated stent-graft (4 fenestration) combined with bilateral iliac branched endograft.
Results: The surgery was performed under general anesthesia, in angiographic suite. Percutaneous access was performed to the common femoral arteries and the hemostasis was achieved with preclose technique. The step of procedure provide the deployment of the fenestrated endograft, cannulation and covered stenting of target visceral vessels, and then bilateral iliac branching. Successful aneurysms exclusion with preserved patency of all visceral and pelvic vessels without any endoleak was observed at the completion angiography and at one-month CTA.
Conclusions: The advance technology in endovascular treatment of thoracoabdominal and iliac aneurysms with fenestrated and branched devices seems to offer promising results, lowering perioperative morbidities and mortalities, combined to physician experience and availability of last generation imaging system.

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REPOSITIONING ENDOPROSTESIS FOR ABDOMINAL AORTIC ANEURISM: OUR EXPERIENCE

D. TREVISAN[1], S. MAIDA[1], M. GUGLIELMETTI[1], M. GALLI[2], G. DE NITTIS[2], F. RUSSO[2], R. CARONNO[1]

[1] Chirurgia Vascolare, Sant'Anna, Como, Italia
[2] Cardiologia Interventistica, Sant'Anna, Como, Italia

Objective: We evaluted our experience in using of the repositioning endoprostesis; the study is on 80 cases in 24 month, even in the presence of "hard neck"
Methods: The mean age is 74.5 years (range 61-87); 86% (n.69) male; the average diameter of the aneurysm was 57.5 mm (range 51-85 mm); 4 cases (5%) were rAAA in Emergency / Urgency. In 5 cases (6.2%) we have associated an endovascular treatment of the renal artery (in 1 case a single vessel, and in 4 cases both renal arteries) with Chemney Tecnique. In ten cases (12.5%) were placed coils for the prevention of endoleak.
Results: One death in the immediate post-operative, secondary at complication in percutaneous femoral access level. Midterm follow-up (24 mounth): not type I endoleak A. One case (1,25%) of reperfusion of the aneurism bag from the iliac arteries, which necessitated treatment by iliac prosthesis; 15 (18.7%) cases of II type endoleaks: 6 cases from lumbar arteries (one treated with coils and glue); in 5 cases the reperfusion of the bag was done by the inferior mesenteric artery; one of these was treated after one year with the surgical (laparoscopic) occlusion of the inferior mesenteric artery, complicated by ischemia of the colon; the remaining 4 cases are caused by the simultaneous patency of one vessel lumbar and inferior mesenteric artery. No endoleak type III and endotension. 62 treatments (77.5%) gave excellent results in the short and medium term follow-up.
Conclusions: We beneficial use of repositioning prosthesis because: It is possible to be more "aggressive" in the first proximal release and more precise even in the treatment of angle neckIt make suitable later to correct the position of endoprostesis, we can "accommodate" better the prosthesis for the proximal seeling .The medium-term results are entirely overlap to the literature, the most advantage for the absence of first type endoleaks.

SUPERFICIAL FEMORAL ARTERY STENTING DISRUPTION TREATED BY PERIPHERAL ENDOGRAFT

M. FORMICONI[1], A. RIZZO[2], P. SIRIGNANO[2], M.F. GIANNONI[2], F. SPEZIALE[2]

[1] Scuola di specializzazione Chirurgia Vascolare, Università "Sapienza", Roma, Italia
[2] Chirurgia Vascolare, Università "Sapienza" Policlinico Umberto I, Roma, Italia

A 62-years-old man was admitted to our Unit for the sudden onset of pain to the medio-lateral right thigh. One year before, the patient underwent, in another hospital, endovascular revascularization of the right superficial femoral artery. At that time, two nitinol stents 7x15 and 6x15mm were implanted in SFA from the origin to the medial portion. At hospital readmission, he presented no symptoms and normal SFA patency. Duplex Scan Ultrasound showed multiple disruptions of the implanted stent with a SFA pseudoaneurysm. A computed tomographic angiography confirmed these findings. Through a left femoral approach a direct engagement of the right common femoral artery was achieved by a 7 F long-sheath. Fractured stents were crossed with standard hydrophilic guide-wire and 7x250mm peripheral endograft was deployed covering the entire stented artery and it was post-dilated with a balloon catheter. Completion angiogram demonstrated a complete exclusion of the pseudoaneurysm without evidence of endoleak and good patency of the distal "run-off" vessels. Pain completely disappeared on the first post-operative day. DUS demonstrated good patency of the SFA and the popliteal artery. After one month of follow-up the patient reported no further events and CTA control revealed good patency of the endograft and a complete exclusion of the pseudoanerysm. Onset of SFs with Protegé device is a rare event[i] generally related to implantation of the stent (s) in the distal portion of the SFA; only few reports describe SF in the proximal portion of the SFA. Our case represents an unusual clinical manifestation of SF leading to symptoms and pseudoaneurysm formation.

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TYPE B AORTIC DISSECTION AFTER EVAR: AN EMERGING COMPLICATION

E. PACIARONI[1], C. PRANTEDA[1], P. SIRIGNANO[2], A. RIZZO[2], F. SPEZIALE[3]

[1] Scuola di specializzazione Chirurgia Vascolare, Università "Sapienza" Policlinico Umberto I, Roma, Italia
[2] Chirurgia Vascolare, Policlinico Umberto I, Roma, Italia
[3] Chirurgia Vascolare, Università "Sapienza" Policlinico Umberto I, Roma, Italia

A 51-year-old man was admitted electively for an asymptomatic 65-mm infrarenal abdominal aortic aneurysm and a 40 mm thoraco-abdominal aorta ectasia. The patient refused surgical repair and underwent EVAR. Post-operative course was uneventful; we scheduled a follow-up study to assess the evolution of thoracic aortic ectasia. Standard follow-up by computed tomography angiography (CTA) showed the exclusion of the aneurysm and the stability of the thoracic ectasia. After 6 months, the patient came back to our emergency department for sudden onset of chest pain. A further CTA showed an aortic dissection with a 51-mm aneurysmal dilatation, originating from VI intercostal space to the origin of renal arteries associated with complete shrinkage of the abdominal aneurysm. Endovascular procedures ensure high levels of feasibility and low complications rate. A rare complication is an acute aortic syndrome. The risk of acute aortic syndrome after TEVAR, generally associated to mechanical stresses due to foreign body, is ranged between 1.95 and 6.8%; there have been no reports published to date indicating the risk of aortic dissection following EVAR. In the few cases described, the dissection was in the early postoperative period, often in the absence of symptoms. Etiology remains unknown. Two main factors have been implicated: unfavorable anatomy and iatrogenic aspects, related to technical aspects of the procedure or the use of active anchoring systems. Moreover, the progression of the disease could depend by the continuous micro-traumas, each cardiac systole, due to contact with the wall of the endoprosthesis, angulation of the aortic wall leads to uneven stress points from a device that tries to resume its straight configuration. A close follow-up in patients with complex lesions of the aorta is desirable to identify patients at higher risk of this complication and prevent its onset.

MANAGEMENT OF TEMPORARY STOMA AFTER ELECTIVE SURGERY IN AN ITALIAN TERTIARY CARE REFERRAL CENTER FOR RECTAL CANCER

A. MASSOBRIO, S. SCABINI, E. RIMINI, E. ROMAIRONE

Chirurgia Oncologica e dei Sistemi Impiantabili, IRCCS San Martino IST, Genova, Italia

Objective: Rectal surgery for cancer often requires the creation of a temporary stoma to protect an anastomosis that can be jeopardized by neoadjuvant therapy. The recanalization can be performed either immediately or several months after surgery (early or delayed). This series reports about the results in the management of the stoma in a tertiary care referral center for rectal surgery.
Methods: Two hundred and seven consecutive patients (M: 56; F: 53; average age: 71 years) undergoing surgery for rectal cancer have been included in this report . All patients underwent anterior rectal resection. Overall, a stoma was performed in 109 patients (53%): it was an ileostomy in 63, a colostomy in 46. Among these, adjuvant chemotherapy was performed in 58 patients (53.2%).
Results: The stoma was temporary in 92 cases (54 patients with ileostomy and 38 with colostomy). Early recanalization was performed in 3 cases (2.75%). The average range from surgery to recanalization was 150.46 days (168 days after colostomy, 138 after ileostomy; overall SD 139.8; p>0.30). The only statistical difference affecting recanalization was the adjuvant therapy, with a later recanalization performed after the therapy (p=0.009).
Conclusions: In our experience ileostomy was performed in the majority of patients who underwent surgery for rectal cancer and a later recanalization was preferred: early recanalization is currently rarely performed.

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RIGHT-SIDED VERSUS LEFT-SIDED COLECTOMIES FOR CANCER: SURGICAL OUTCOMES AND NOVEL CONSIDERATIONS

G. CARCANO[1], S. RAUSEI[1], G. LIANOS[2], A. MANGANO[1], D. IOVINO[1], F. ROVERA[1], G. DIONIGI[1], L. BONI[1]

[1] Department of Surgery, University of Insubria, Varese, Italia
[2] Department of Surgery, University of Ioannina, Ioannina, Grecia

Objective: The aim of this study is to compare short-term outcomes of right- versus left colectomies performed for cancer.
Methods: This study includes 305 consecutive patients with adenocarcinoma treated by laparoscopic or open colectomy. Right colectomy (defined by the resection of ileocecal valve) has been compared with left colectomy (defined by the resection of a colon part different from the right one and the extraperitoneal rectum). The study end points were the first flatus day, the first evacuation day, the first day of postoperative solid oral diet intake and the postoperative hospital stay length. The groups were stratified according to the median value for each end point.
Results: Right colectomies were 140 (45,9%) and left colectomies were 165 (54,1%). The cut-off values for the considered end points were 3, 5, 4 and 8 days, respectively. The first day of postoperative solid oral diet intake (45,0% of the patients started a solid oral diet intake before the 4th post-operative day after right colectomy versus 62,0% after left colectomy, p=0,003) and the length of postoperative hospital stay (47,0% of the patients had hospital discharge before the 8th postoperative day after right colectomy versus 60,5% after left colectomy, p=0,020) are significantly associated with the type of resection.
Conclusions: This retrospective analysis showed that postoperatively the colon cancer patients treated by right-sided colectomy assumed later solid oral diet and, consequently, presented a longer postoperative hospital stay in comparison with the patients treated by left-sided colectomy.

MAST CELLS DENSITY POSITIVE TO TRYPTASE CORRELATE WITH ANGIOGENESIS IN PANCREATIC DUCTAL ADENOCARCINOMA PATIENTS UNDERGONE TO SURGERY

M. AMMENDOLA[1], R. SACCO[1], G. SAMMARCO[1], G. GALLO[1], G. VASCIO[1], R. ROMANO[1], S. MONTEMURRO[2], G. RANIERI[3]

[1] Department of Medical and Surgery Science, Clinical Surgery Unit, University of Catanzaro "Magna Graecia" Medical School, Catanzaro, Italia
[2] Surgery Unit, National Cancer Research Centre, "Giovanni Paolo II", Bari, Italia
[3] Interventional Radiology Unit with Integrated Section of Translational Medical Oncology, National Cancer Research Centre, "Giovanni Paolo II", Bari, Italia

Objective: Literature data suggest that cells such as mast cells (MCs), are involved in angiogenesis. MCs can stimulate angiogenesis by releasing of several pro-angiogenic cytokines stored in their cytoplasm. In particular MCs can release tryptase, a potent in vivo and in vitro pro-angiogenic factor. Nevertheless few data are available concerning the role of MCs positive to tryptase in primary pancreatic cancer angiogenesis. This study analyzed MCs and angiogenesis in primary tumour tissue from patients affected by pancreatic ductal adenocarcinoma (PDAC).
Methods: A series of 31 PDAC patients with stage $T_{2\text{-}3}N_{0\text{-}1}M_0$ (by AJCC for Pancreas Cancer Staging 7th Edition) were selected and then undergone to surgery. Tumour tissue samples were evaluated by mean of immunohistochemistry and image analysis methods in terms of number of MCs positive to tryptase (MCDPT), area occupied by MCs positive to tryptase (MCAPT) microvascular density (MVD) and endothelial area (EA). The above parameters were related each to other and with the main clinico-pathological features.
Results: A significant correlation between MCDPT, MCAPT, MVD, EA group to each other was found by Pearson t-test analysis (r ranged from 0.69 to 0.81; p-value ranged from 0.001 to 0.003). No other significant correlation was found.
Conclusions: Our pilot data suggest that MC positive to tryptase may play a role in PDAC angiogenesis and they could be further evaluated as a novel tumour biomarker and as a target of anti-angiogenic therapy.

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LEFT HEPATECTOMY FOR CAROLI'S DISEASE

B. NARDO[1], A. ZULLO[2], M. CANNISTRÀ[2], G. TOMAINO[2], I. PALAIA[2], V. DIACO[2], R. SACCO[2]

[1] Dipartimento di Scienze Mediche Chirurgihe, S. Orsola Hospital, University of Bologna, Bologna, Italia
[2] Dipartimento di Chirurgia Generale, A.O. Mater Domini/ Università Magna Graecia, Catanzaro, Italia

Objective: Caroli's disease is a congenital disease and it consists in segmental malformation with single or multiple intrahepatic cysts. It was described by Carolì in 1958 and then it was included by Todani (1977) in the classification of congenital dilation of biliary ducts as type V. It is a rare disorder (incidence 1:1.000.000), female people are most affect than man (F/M 4:1), symptoms reveal in adulthood and recurring more in oriental than occidental population.
Methods: We introduce a case of a forty-years old woman with appearance of right hypochondrium pain associated to fever. RMN showed cystic expansions of the intra-hepatic bile ducts, with presence of sludge and stones in the left liver involving also the segment 4. These cysts, initially isolated became confluent with recurring cholangitis episodes, and so we decided to submit patient to surgery. A regulated left hepatectomy has been performed through a hydro-dissector US (SONOCA 300), in the absolute respect of the bile-vascular trunks for the remaining parenchyma. The definitive histological examination has confirmed the diagnosis of Caroli's disease.
Results: We described a simple form (type V) called Caroli's disease and a second form in which ductal dilatation is associated with congenital hepatic fibrosis (Caroli's Syndrome), considered, by some authors, different stages of same disease.
Conclusions: In consideration of the young age of patient, the localization of cysts, the recurrent attacks of cholangitis and the literature evidence of malignancy risk of biliary tract, due to longtime inflammatory processes, we performed a left hepatectomy. Transplantation must be considerated an option only in selected case of progression disease when nothing is longer possible.

CONGENITAL CYSTIC DILATATION OF THE EXTRAHEPATIC MAIN BILE DUCT

P. MOGLIA, M. ABUAWWAD, F. CANTORE, M. GIUSSANI, R. MACCHI, S. CATTANEO, P. CANTORE

Azienda Ospedaliera di Como, Como, Italia

Introduction: Congenital cystic dilatation (DCC) of the biliary tract is a very rare condition that most commonly affects females and the Asian population. The expansion may affect the intrahepatic bile duct in its portion, extrahepatic, or both. These anomalies are divided into five types according to the classification of Todani, the most frequent (70%) is that type I (extrahepatic). The DCC are considered precancerous and are associated in the vast majority of cases with presence of an abnormality of the biliary-pancreatic junction (classification according to Komi).
Materials and methods: We report the case of a male patient, western, 71 years old with occasionally diagnosis (access in the emergency room for renal colic) of congenital cystic dilatation of type II. The patient has undergone complete resection of the common bile duct extrahepatic
and reconstruction with bilio-jejunal anastomosis (Roux-en-Y jejunal loop). Histological examination was shown to be a papillary proliferation of adenomatous intestinal type with medium-grade dysplasia.
Discussion: In view of the neoplastic degeneration possibility, the surgery is considered the only treatment of choledochal cyst. The risk of cancer increases with age of the patients (30-40% over 40 years). Conservative treatment is reserved for complications (pancreatitis, cholangitis).

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TRAUMATIC RUPTURE OF THE PANCREAS: OUR CASISTIC, LITERATURE REVIEW AND ROLE OF EARLY ERCP

G. CURLETTI, L. REGGIANI, M. CERIOTTI, A. PERCIVALE, F. MARIANI, G. SACCOMANI

S.C. Chirurgia Generale, Ospedale Santa Corona, Petra Ligure, Italia

We present 3 cases of traumatic pancreatic rupture followed by our unit from 1996 to 2009. They were treated with ERCP at different time from the injury and all of them underwent surgery. We reviewed the literature evidencing the role of early ERCP for diagnosis and as therapeutic act, avoiding surgery in low grade lesions and reducing complication rate in all cases. ERCP must be used, in our convinctions, as soon as possible in grade 1 and 2 lesions and to lower complication rate in grade 3 and 4.

THE EFFECTS OF PREOPERATIVE CHEMORADIOTHERAPY ON LYMPH NODE SAMPLING IN MID-LOW RECTAL CANCER

R. ROMANO, M. AMMENDOLA, G. VESCIO, G. SAMMARCO, R. SACCO

Chirurgia Generale, Policlinico Universitario di Germaneto, Catanzaro, Italia

Objective: The lymph node sampling is one of the most important phases of the study of the histological specimen and has a significant impact on subsequent treatment. The AJCC recommend that 12 or more lymph nodes should be examined to appropriately stage rectal cancer. It is unclear if this metric is appropriate or achievable for patients who receive neoadjuvant therapy. The purpose of this study is to evaluate the effects of neoadjuvant chemoradiotherapy on the lymph node yield in patients with rectal cancer.
Methods: From January 2008 to January 2014 were treated 83 patients with rectal cancer. The patients were divided into two groups, depending on the distance from the anal margin: 52 (62,6%) extraperitoneal rectal cancer and 31 (37,4%) intraperitoneal rectal cancer. Patients received either chemoradiotherapy or no neoadjuvant treatment before undergoing total mesorectal excision for rectal cancer.
Results: On average, the lymph nodes removed were 21.14 (range 5-76) and the average of metastatic lymph nodes was 8.56 (range 1-68). In the first group (neoadjuvant radiochemotherapy) the average of the lymph nodes harvested was 14.73 (range 6-35) with an average of 4.0 metastatic lymph nodes (range 1-5, 14.2%), while in the second group (surgery alone) the average of the lymph nodes removed was 24.67 (range 5-76) but with an average of 10.96 metastatic lymph nodes (range 1-68, 25.5%).
Conclusions: The analysis of our cases showed a significant data comparing patients who have undergone neoadjuvant RCT compared to untreated cases: the radiation treatment makes it difficult to count and analysis of the lymph nodes but, on the other hand, involves a positive result on the number of metastatic lymph nodes in the first group than the second.

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MULTIPLE HEPATIC RESECTIONS FOR RECURRENT COLORECTAL LIVER METASTASES IN A SINGLE PATIENT

B. NARDO[1], A. ZULLO[2], M. CANNISTRÀ[2], V. ORSINI[2], R. SACCO[2]

[1] Dipartimento di Scienze Mediche Chirurgihe, S. Orsola Hospital, University of Bologna, Bologna, Italia
[2] Dipartimento di Chirurgia Generale, A.O. Mater Domini/Università Magna Graecia, Catanzaro, Italia

Objective: Hepatic recurrence appears frequently in patients undergoing hepatectomy for colorectal liver metastases (CRLM). Liver resection is the best cure for CRLM in term of overall survival (OS) and disease-free survival both in first metastases and recurrences.
Methods: We report a case of a sixty five-year-old female, who was subjected to three hepatic resection for metachronous CRLM. In June 2007 the patient underwent left hemicolectomy for adenocarcinoma (pT3pN0pM0) with normal tumor markers (TM). After 28 months from colon operation we diagnosed by imaging, first liver metastases treated with neo-adjuvant chemotherapy followed by resection of segment S 8; the patient treated with adjuvant CHT. After 18 months from first hepatic resection TC showed a new metastases without alteration of TM and we decided to perform another resection. Five months later the CEA level was increased (7.82 ng/ml) and TC showed a new hepatic metastases (5 cm) in S 2; the patient was firstly treated with FOLFIRI plus Avastin with a decrease of metastases dimension equal to 50% at first control and a disappearance of CRLM after other 4 months. In this period TM became again normal. We continued monitoring imaging and 24 months from second resection it was drawn attention to a metastases (2.6 cm) in S2 accompanied with new increase of CEA (6.29 ng/ml). For this reason we have decided to undergo patient to third hepatic resection. The postoperative course was normal and the patient was discharged after 7 days.
Results: We documented a reduce recurrence-free survival (five months) between second resection and the appearance of third metastases in the presence of an increase of CEA. Mortality risk is comparable with the first liver resection with significant benefits in longer Overall Survival when liver recurrence is solitary, unilobular, small size (≤5cm), without extra-hepatic recurrence and it's possible an R0 resection saving more parenchyma.

THE TREATMENT OF PERIANAL FISTULAS: OUR EXPERIENCE

G. GALLO, F. FERRARI, A. CARPINO, M. AMMENDOLA, G. SAMMARCO, R. SACCO

Cattedra di Clinica Chirurgica, Università "Magna Graecia" di Catanzaro - Policlinico Universitario, Catanzaro, Italia

Objective: The treatment of perianal fistulas aims to eradicate the sepsis and the fistulous tract, while preserving the maximum amount of anal fuctions. In fact, a proper identification of the internal opening and a careful delineation of the anatomy of anal fistulas in relation to anal sphinters factors are most important to prevent the recurrence preserving continence.
Methods: In the three years 2010/12 were submitted to surgery for complex fistula 91 patients (67M, 24F) with the age range between 17 and 75 years. Of these 91 patients 69 had a perianal fistula (40 with high transphincteric fistula, 14 with intersphinteric fistula and 15 with low transphincteric fistula) while the remaining 22 had ischio-rectal fistula. We performed 5 interventions by the method VAAFT.
Results: In the 12 patients who has not been identified the mucous orifice there were 5 recurrences (42%).
In the remaining 51, treated with slow section of the sphincters, there were 2 recurrences (4%) and 2 gas incontinence (4%). In the 5 interventions by the method VAAFT we obtained the following results: healing in twentieth matchday; only two checkups in ambulatory incurred in seventh and fourteenth day; return to work in the third post-operative day.
Conclusions: In conclusion we confirm that The main reason for the recurrence of fistula after surgery is the failure to locate its internal opening. The VAAFT offers greater advantages in terms of comfort for the patient and of complications sphincter, although burdened by a higher cost of the instrumentation.

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THD SLIDE: OUR EXPERIENCE

G. GALLO, F. FERRARI, A. CARPINO, M. PAPANDREA, G. SENA, G. SAMMARCO, R. SACCO

Cattedra di Clinica Chirurgica, Università "Magna Graecia" di Catanzaro - Policlinico Universitario, Catanzaro, Italia

Objective: Various methods have been used in recent years for the surgical treatment of hemorrhoidal disease. Among these, the THD SLIDE certainly had an important development based on the data, already highlighted by Morinaga in 1995, of the hemorrhoidal hyperflow like pathogenetic relevance in the determinism of hemorrhoidal disease. In this work we analyze the data of our experience with THD-SLIDE DEVICE.
Methods: In Our Operative Unit of General Surgery were treated ,in 2012 , with THD SLIDE 24 patients with hemorrhoidal disease including 16 males and 8 females with an age range 40 to 60 years. All patients had a grade of haemorrhoidal prolapse lower than 1.5 cm from the anal rhyme except for 2 that had a prolapse greater than 2 cm.
Results: Our results showed a post-operative pain rated with VNS scale (as shown by Wiel Marin) of 5.2. The days of hospitalization were on average 2 except in one case with early post-surgical bleeding. The Median follow-up was of 10 mounth.
However there have been the following early complications: 3 cases of bleeding; 6 cases of thrombosis. Late complications were the following: 4 cases of residual disease, 2 cases of recurrence, 5 cases of late bleeding and 4 of thrombosis.
Conclusions: In our experience the THD slide method is repeatable and safe for patients with prolapse lower than 1.5 cm. Our data showed a reduction of post-operatory pain and reduction in hospitalization with rapid shooting in the work setting.

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MULTIPLE BILOBAR COLORECTAL LIVER METASTASES: DIFFERENT TECHNIQUES, A COMMON GOAL. A COMMUNITY HEALTH CARE REGIONAL DISTRICT EXPERIENCE

M. CERIOTTI[1], G. GRISERI[2], A. PERCIVALE[1], A. FRANCESCHI[2], L. REGGIANI[1], R. PELLICCI[3]

[1] Ospedale Santa Corona, Pietra Ligure (SV), Italia; [2] Ospedale San Paolo Savona, Savona, Italia; [3] Asl 2 Savonese, Ospedale Santa Corona, Pietra Ligure (SV), Italia

Background: Over the last decade, the surgical approach to metastatic colorectal cancer radically changed, passing from a "pure" surgical form to an Oncosurgical model. Nowadays we are experiencing the evolution and the more profound interaction between chemotherapy and surgery and we are facing with new and alternative surgical techniques for the treatment of liver metastases. Applying new integrated strategies (both surgical and chemotherapic), the overall resectability rate for patients presenting with liver colorectal metastases (CLMs) increased from 20 to 30-45%.
Aim of the study is to compare the outcomes of patients affected by multiple bilobar CLMs treated with two oncosurgical approaches: the Two Stage Hepatectomy strategy (TSH) and the combination of Hepatic Resections plus RFA (so called "Chip and Burn", CB).
Materials and methods: This study was performed in two district community hospitals (S. Paolo Savona and S. Corona Pietra Ligure), belonging to the same territorial compound (Asl 2 Savonese), sharing the same surgical strategy, protocols and hepatobiliary team. From September 1997 to April 2013, 48 patients underwent an hepatectomy for multiple bilobar CLMs in our centers. We analyzed those patients dividing them into two groups of surgical treatment: TSH and CB groups. We excluded from the analysis 15 patients who weren't fit to complete the second stage of TSH due to progressive disease or worsening of general conditions. In both groups was administered the chemotherapic regimen that was recommended by the international guidelines. Short-term outcome and overall survival were compared in patients having TSH and those treated by CB strategy.
Results: Of 48 patients undergoing hepatectomy for multiple bilobar CLMs, 29 (60.4%) underwent a TSH strategy and 19 (39.6%) were submitted to CB. The 90 days mortality rate following hepatectomy was 2.08% overall (0 versus 5.26% in TSH and CB respectively). Mean overall survival was 40% (44% TSH, 35% CB). Median survival was 35 moths overall, 37 and 27 moths in the TSH and CB groups respectively. Three and five-year overall survival rates were 47.7 and 30.8% (55 and 37.7% in the TSH group; 37 and 21% in the CB group). DFS patients are 4 in the TSH and 1 in the CB group (14% and 5% respectively).
Conclusions: In this limited and low powered study, both the procedure seem to be safe and effective but TSH strategy appears to have a better outcome both in terms of 3 and 5 years and disease free survival.

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SYNCHRONOUS COLORECTAL LIVER METASTASES: SIMULTANEOUS VS DELAYED LIVER SURGERY IN AN ITALIAN COMMUNITY HEALTH CARE REGIONAL DISTRICT

M. CERIOTTI[1], G. GRISERI[2], A. PERCIVALE[3], A. FRANCESCHI[2], L. REGGIANI[4], R. PELLICCI

[1] Asl 2 Savonese, Ospedale Santa Corona, Pietra Ligure (SV), Italia; [2] Asl 2, Ospedale San Paolo, Savona, Italia
[3] Asl 2, Ospedale Santa Corona, Pietra Ligure, Italia; [4] Asl 2, Santa Corona, Pietra Ligure (SV), Italia
[5] Asl 2, Ospedale Santa Corona, Pietra Ligure (SV), Italia

Background and aim: The optimal surgical strategy for the treatment of resectable synchronous colorectal liver metastases (CLMs) is still unclear.
According to literature, simultaneous resection seems to be safe and efficient, both avoiding a second major operation (with a positive impact on postoperative immunodepression, early instigation of adjuvant therapy and patient's discomfort) and reducing social costs.
Moreover, to perform a simultaneous technique, two different specialized surgical teams are needed (mainly for rectal and hepatic resection). That is not so easy to obtain in most community district hospitals.
Aim of the study is to compare the outcomes of the simultaneous colorectal and hepatic resection (SR) with those of the delayed strategy (DR) in patients presenting with synchronous CLMs.
Materials and methods: This study was performed in two district community hospitals (S. Paolo Savona and S. Corona Pietra Ligure), belonging to the same territorial compound (Asl 2 Savonese), sharing the same surgical strategy, protocols and hepatobiliary team. All patients with synchronous CLMs who underwent hepatic resection between October 1998 and October 2013 were retrospectively analyzed. We excluded from the study 30 patients who underwent a two stage hepatectomy for multiple bilobar metastases ad one patient who quits the follow up. Short-term outcome and overall survival were compared in patients having SR and those treated by DR.
Results: Of 69 patients undergoing hepatectomy for synchronous CLMs, 50 (72,5%) had a SR and 19 (27,5%) had a DR. The 90 days mortality rate following hepatectomy was 7,2% in the two groups (6% versus 10,5% in SR and DR respectively). Among those 6 patients who died within 90 days, 3 belong to SR and 3 to the DR group and only 2 patients died for surgical related complications. The mean survival was 32 months in the two groups (32 for SR group, 34 for DR group). Three and five-year overall survival rates were 44 and 29% (44 and 28% in the SR group; 43 and 33% in the DR group).
Conclusions: In this limited and low powered study, combined strategy seems to be safe in patients with synchronous CLMs without clear differences in terms of mortality and overall survival compared to a delayed procedure. Nevertheless, considering data regarding 90 days mortality, SR in patients with multiple comorbidities should be carefully considered.

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ADVANCED TECHNOLOGIES IN HEPATOBILIARY SURGERY: OUR INITIAL EXPERIENCE AT UMG-CATANZARO

B. NARDO[1], A. ZULLO[2], M. CANNISTRÀ[2], V. ORSINI[2], R. SACCO[2]

[1] Dipartimento Scienze mediche e chirurgiche, Sant'Orsola Hospital- University of Bologna, Bologna, Italia
[2] Dipartimento di Chirurgia Generale, A.O. Mater Domini/ Università Magna Graecia, Catanzaro, Italia

Objective: Liver surgery is stepping into an age of "precise and tailored resection" mainly due to modern technologies.
Methods: We report our initial experience at University *Magna Graecia* of Catanzaro in collaboration with *Alma Mater Studiorum* of Bologna in term of hepatobiliary surgery. Since 2013 March at 2014 July we had made 27 operations in 14 operative days. They include major as well as minor hepatic resection (hepatectomy, lobectomy, segmentectomies including S1, wedge resection) for 16 colorectal liver metastases (CRLMs), 1 carcinoid liver metastases and 5 HCC. We had treated also 2 hepatic symptomatic cyst, which were excise; 1 biliary cystadenoma, which occupied all central part of liver with compression of cava, portal vein and implication of bile ducts whereby it was necessary a mesohepatectomy with anastomotic reconstruction of right and left bile duct, and, recently a Carolì's disease confined to left lobe and symptomatic. We used intemittent Pringle maneuver whenever necessary and a central vein pressure was kept below 5 mmHg to reduce bleeding. Before resection an intraoperative ultrasound was always performed. Liver parenchymal transection was carried out with several instruments as Harmonic (US), Tissue-Link dissecting sealer, hydro-dissector US (SONOCA 300), and, at last, Cavitron ultrasonic surgical aspirator (CUSA) which distinguished for more precision. In few selected cases a RF ablation with RITA was carried out. Hemostasis was made with electrocautery and Argon laser or topical hemostatic agents (Tabotamp, Tachosil, or Floseal).
Results: Early post-operative morbidity was around 14% and no mortality has been reported. The mean hospital time recovery was 7 days.
Conclusions: We believe that following the correct indications, the precise operative time and with the support of advance technologies and surgical expertise, is possible to obtain good results in advanced hepatobiliary surgery.

LAPARO-ENDOSCOPIC MANAGEMENT FOR CHOLELITHIASIS AND COMMON BILE DUCT STONES

C. RIZZETTO[1], D. DA ROS[1], R. BONADIO[1], M. SCHIANO DI VISCONTE[1], M. TRETJAK[2], G. MUNEGATO[1]

[1] Chirurgia Generale, Conegliano, Italy, Azienda Ospedaliera ULSS7, Conegliano, Italia
[2] Università di Trieste, Ospedale di Cattinara, Trieste, Italia

Objective: The ideal management of cholelithiasis and common bile duct stones (CBDS) is still a matter of debate. A single stage option based on laparoscopic cholecystectomy (LC) followed by an intraoperative endoscopic retrograde cholangio-pancreatography (ERCP) seems to offer some advantages. The aims of the study is to investigate the feasibility, results and procedure related complications.
Methods: A retrospective charts review was done from all consecutive patients undergone to LC and ERCP between 2003 and 2012 at our surgical unit. We reviewed patients' characteristics, indication for surgery, conversion rate to open procedure, post-operative complications and hospital stay.
Results: During the study period, 184 patients (male 76; female 108) were identified with a median age of 69 years (IQR 55.5-77.5). 159 patients underwent an urgent procedure (86.5%), while 25 patients were operated electively. Laparoscopic procedure was attempted in all patients and a conversion to open procedure was necessary in 9 (4.9%). The endoscopic cannulation technique was successful in all patients. The primary stone clearance rate was 98.4% (181/184). There was no mortality. A complication was recorded in 12 patients (6.5%): pancreatitis in eight, small bleeding in two, cholangitis in one, bile leakage from the cystic duct in one. The median hospital stay was 7 days (IQR 10-15).
Conclusions: Laparo-endoscopic management of CBDS is feasible, safe and has a high stone clearance rate. Obviously, the technique requires logistics to perform LC and ERCP in the operating room, but is a single stage option that may reduce the hospital charges.

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SHOULD LAPAROSCOPIC CHOLECYSTECTOMY BE PERFORMED REGARDLESS OF AGE?

C. RIZZETTO[1], D. DA ROS[1], M. SCHIANO DI VISCONTE[1], M. TRETJAK[2], G. MUNEGATO[1]

[1] Chirurgia Generale, Azienda Ospedaliera ULSS7, Conegliano, Italia
[2] Università di Trieste, Ospedale di Cattinara, Trieste, Italia

Objective: Since elderly patients become a growing part of the population and advanced age is associated with an increase in post-operative complications, this study was conducted to evaluate the outcomes of laparoscopic cholecystectomy (LC) in patients aged 80 years or older.
Methods: A retrospective chart review was done of LC performed in a consecutive series of elderly patients between 2003 and 2012 at our surgical unit. We reviewed patient' characteristics, indication for surgery, comorbid conditions, conversion to open procedure, postoperative complications and hospital stay.
Results: During the study period, 102 patients (male 39; female 63) underwent LC with a median age of 83 years (IQR 80.5-86). Of these, a comorbid condition was present in 45 patients (44%). Seventy patients (68.5%) underwent an urgent procedure, while 32 patients (33%) were operated electively. A conversion to open procedure was necessary in 5 (4.9%). An intraoperative endoscopic retrograde cholangio-pancreatography was necessary in 23 patients (22.5%) for associated common bile duct stone presence. Mortality was nihil and morbidity rate was 18.6%. No bile duct injury occurred. The median hospital stay was 9 days (IQR 7-14).
Conclusions: LC in extremely elderly is feasible and well tolerated, that can be accomplished with acceptable low morbidity even as an emergency procedure.

OPEN ABDOMEN MANAGEMENT OF INTRA-ABDOMINAL INFECTIONS: A PROGNOSTIC FACTORS ANALYSIS

F. AMICO, S. RAUSEI, V. QUINTODEI, M. LAVAZZA, F. ROVERA, L. BONI, G. CARCANO, G. DIONIGI

Department of Surgery, University of Insubria, Varese, Italia

Objective: No conclusive results on the efficacy and timing of management of an open abdomen (OA) are available, particularly in the setting of intra-abdominal infections. We retrospectively analyzed outcomes and risk factors in a large series of patients managed with an OA in an effort to clarify this issue.
Methods: We reviewed the records of 148 patients who underwent treatment with an OA, considering factors related to patient, disease, medical management, and surgical treatment. The end points of the bi-variable analysis were 1-y mortality, calculated from the time of an initial OA procedure, and definitive fascial closure.
Results: Most patients managed with an OA had one of several types of peritonitis. Many patients had severe clinical conditions (mean Acute Physiology and Chronic Health Evaluation [APACHE] II score was nearly 9 for the entire study population). With regard to surgical management, the mean (+ SD) number of abdominal revisions was 4.8 + 9.1 during a mean duration of treatment with an OA of 12.0 + 9.8 d. The overall mortality in the study was 26%. Bi-variable analysis revealed factors associated with overall mortality to be age, renal and respiratory co-morbidities, blood pressure, blood glucose and creatinine levels, and APACHE II score. The rate of definitive fascial closure was 75%. Factors negatively associated with fascial closure were respiratory co-morbidity, post-operative mesenteric ischemia as an indication for OA, blood glucose and creatinine levels, and duration of an OA.
Conclusions: Patients' pre-operative clinical status strongly influences their response to surgical treatment. The management of OA does not adversely affect the survival of patients with intra-abdominal infections, but factors related to the management of OA (duration of OA) seem to affect the possibility of definitive fascial closure.

NEUROPATHIC PAIN IN HERNIA REPAIR: PRELIMINARY RESULTS

G.P. SAPIA, B. FRANZOSO, F. BARACCHI, G. GIRAUDO, F. BORGHI

Azienda Ospedaliera Santa Croce e Carle, Ospedale Santa Croce, Cuneo, Italia

Objective: To evaluate the impact neuropathic pain (NP) after surgery for hernia repair and possible medical and/or surgical approach.
Methods: Files of patients who have undergone hernia surgery from January 2010 to December 2013 and subsequently were referred to Algology for NP have been all clinically examined by a commission comprising a surgeon and an algologist, had to undergo Q-Sense test and to complete DN4 questionnaire.
Results: We have picked out 30 patients (23 males, 7 females). The median age at the time of surgery was 53 years (22-81). Among them, 12 didn't want to take part in this study. The remaining 18 patients were examined by a surgeon and an algologist, and DN4 questionnaire and Q-Sense test were administrated. In eight cases (44%), pain didn't have neuropathic features and pain relief was obtained by drugs. In eight cases (44%) "*certain*" NP was observed, in two cases (11%) "*probable*" NP. All patients had similar pharmacological treatment with drug therapy (opioids, NSAID, GABAergic, antidepressants, steroids, local anaesthetics, capsaicin cream, anaesthetic plasters). In one case (6%) non responsive to medical therapy pain relief was obtained by re-intervention, during which nerve entrapment was observed, and therefore the surgeon performed prosthesis removal, neurectomy, and according to Bassini hernioplasty.
Conclusions: Post-surgical NP represents a complication whose impact is still difficult to evaluate. Medical therapy remains a milestone for its treatment, leaving the surgery as the last chance for nerve intrapment. Further elements about NP origin will be obtained by other diagnostic methods, with possible consequences for new drugs study.

LAPAROSCOPIC VENTRAL AND INCISIONAL HERNIA REPAIR: RESULTS AND COMPLICATIONS IN A SINGLE CENTER EXPERIENCE

D. APA, E. PUCE, F. ATELLA, E. BREDA, M. LOMBARDI

UOC Chirurgia Generale, CTO A. Alesini, Roma, Italia

Objective: This retrospective study incorporates decades of experience a single Center.
Methods: Between the 2001 the 2012 we have treated 176 patients (94 mens and 47 women) with an average age of 63 years. The 22.7% of patients had a BMI >/= 30. Types of hernias: 108 median incisional, 56 umbilical hernias or epigastric, 3 parastomal , 3 umbilical + inguinal hernias, 6 trocar sites. The 12% were recurrent hernias (open 18 or laparoscopic 2 cases).
The size of the meshes ranged from 8X6 and 30X30 cm (90 Goretex dual-mesh , 10 Composix Bard mesh, 10 Proceed, 10 Dynamesh, 56 Physiomesh Ethicon). We used an overlap of 3-5 cm in all directions. The fixation was obtained with double crown of Protacks combined with transfascial suture only in 6 cases. In incisional suprapubic hernia the mesh fixation included Cooper's ligament. Larger defects were more tacks.
Results: The average surgical time was 50 minutes. We reported two conversions for recurrent hernias and two missed iatrogenic enterotomy with subsequent wound and mesh infection and mesh removals. The Dual-mesh is infected in 4% of cases.
The mean follow-up was of 72 months. The recurrence rate (3.9%) were significantly related to the size and type of hernia (incisional hernia) , wound infection and body mass index (BMI). Bulging and shrinkange occurred in 4% of major defects. Seroma (3,4%) was detected especially in reoperation and wound infections. A post-operative pain was transient in 4 cases.
Conclusions: The laparoscopic approach has a significantly lower risk for wound infections in comparison with the open technique. For obese patients laparoscopic repair is preferred because it reduce the wound infection rate and complications. The size of defect, wound infections and proper technique are determinant in short and long term results.
In large and very large ventral and incisional hernias the component separation can be considered in combination with laparoscopic mesh technique.

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LIGHTWEIGHT POLYPROPYLENE MESH & ABSORBABLE TACKS IN LAPAROSCOPIC VENTRAL AND INCISIONAL HERNIA REPAIR

O. IORIO, G. CAVALLARO, A. IOSSA, M. AVALLONE, S. RUSCIO, M. RIZZELLO, G. SILECCHIA

Department of Medico-Surgical Sciences and Biotechnologies, "Sapienza" University of Rome, Latina, Italia

Objective: Laparoscopic repair of ventral/incisional hernias (LVIHR) has gained popularity, since many studies and a recent meta-analysis reported encouraging results when compared to open repair. The choice of the mesh and fixation methods is of paramount importance. No conclusive data exist on the choice of the lightweight meshes and new absorbable fixation devices.
The aim of this study was to evaluate the effectiveness of lightweight polypropylene mesh and absorbable tacks in LVIHR.
Methods: 72 consecutive LVIHR procedures performed in 71 patients (M:F 38:33, mean age 46.7 +/- 12.1 years), using lightweight polypropylene mesh fixed by "U" shaped absorbable tacks, were prospectively evaluated for surgical outcome, acute and chronic pain, return to life activities, recurrence rate. Preoperative study of the hernia defect was performed by ultrasounds or computed tomography and hernias were classified according to EHS classification. 26 were primary ventral hernias, 39 incisional, 7 recurrent hernias. Exclusion criteria were: BMI > 30, chirrosis, uncompensated diabetes, corticosteroid chronic treatment, strangulated/incarcerated hernia, width > 10 cm.
Results: All procedures were carried out by laparoscopy. Lightweight polypropylene allowed easy onlay positioning with a proper overlap of the defect (> 3cm). Mean operative time was 55.9 +/ 24.8 minutes (range 38-145). No major complications were reported. Mean post-operative stay was 1.8 days. Post-operative pain was evaluated at 24 and 48 hours after surgery, at one week and one month after surgery, using the Visual Numeric Scale (VNS). All patients achieved pain control using i.v. paracetamol. No patient reported a score index > 6 within the 48 hours. No patient showed chronic pain. Two patient showed hernia recurrence respectively at 5 and 6 months and were resubmitted to successful LVIHR. At 12-month follow-up no further recurrence was reported.
Conclusions: The use of totally absorbable fixation system seems to offer an effective alternative with good results in terms of hernia recurrence rate and post-operative acute and chronic pain. Further studies with long term are needed in order to compare absorbable vs metallic tacks.

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GORE BIO-A® ASSOCIATED WITH V.A.C. SYSTEM IN PATIENTS TREATED WITH "OPEN ABDOMEN"

R. MALATESTI, M. ANGELINI, A. BIANCAFARINA, M. SCRICCIOLO, T. AMATO, M. DE PRIZIO

AUSL8, Ospedale San Donato, Arezzo, Italia

Objective: Patients who undergone redo surgery for secondary peritonitis represent a real challenge for the surgeon. Mortality and morbidity are associated not only to the etiology of peritonitis but more value seems to have the procedure used to close abdomen. This study shows our experience treating patients with open abdomen using Gore Bio-A® associated to the V.A.C. system.
Methods: From September 2011 to April 2014, 7 pts (3 female, 4 male, middle age 66 , range 51-80) were treated at General Surgery Unit, San Donato Hospital, Arezzo, for secondary peritonitis. 5 pts were treated using V.A.C. system over Gore Bio-A® at the same time, in 2 cases V.A.C. system was used later (2 and 4 days after the redo surgery respectively).
Results: Complete laparotomy wounds healing was achieved between 20-40 days after redosurgery, range 32 days. V.A.C. system was changed every 2-4 days (range 3 days), in every patient. No local morbility occurred in postoperative time, one patient died 70 days after surgery not for morbility associated to laparotomy. All patients undergone to redo surgery with open abdomen treated with Gore Bio-A® a and V.A.C.system association didn't show incisional hernias at the follow up (range 4-30 months, range 14 months).
Conclusions: The procedure described is a safety and effective technique for the treatment of open abdomen and it may be possible a larger extension of its use. A longer follow up will be necessary to evaluate the open abdomenl treatment.

RARE CASE OF DESMOID TUMOR OF THE ABDOMINAL WALL ASSOCIATED WITH FAMILIAL ADENOMATOUS POLYPOSIS

P. MOGLIA, M. ABUAWWAD, F. CANTORE, M. GIUSSANI, D. LOVOTTI, A. MATERNINI, F. MATERNINI, P.G. CAPRETTI

Azienda Ospedaliera di Como, Como, Italia

Introduction: The Desmoid tumors (DT) are rare lesions that do not show metastatic potential, having however a high rate of local invasion and recurrence. They account for 3% of soft tissue tumors and 0,03% of all malignancies. The Abdominal desmoid tumors are most often sporadic and rarely associated with familial syndromes, including the familial adenomatous polyposis (FAP). The sporadic form occurs most often on the anterior abdominal wall in young women of childbearing age.
Materials and methods: We present the case of a 35 years old male patient with a family history of FAP. The patient was known to our unit having been already treated by total colectomy and J-pouch ileorectal anastomosis. During follow-up the patient presented to the emergency department of our hospital with a painless mass in the lower abdomen. The radiological findings (CT scan and ultrasound) showed a picture of intestinal obstruction with both intramural and intraperitoneal solid lesions, without any cleavage planes from the intestinal loops. The patient was then underwent laparotomy, radical resection of the abdominal wall mass, repair of the parietal defect with the aid of a polypropylene mesh and macrobiopsy of another not removable mass, located at the mesenteric level. Histological examination revealed a desmoid tumor. The patient was discharged without postoperative complications and addressed to the regional referral center for adjuvant treatment.
Discussion: DT are benign fibrous neoplasms, originating from musculoaponeurotic tissue. They demonstrate aggressive growth, and have a high rate of local recurrence. Surgery is the treatment of choice, and adjuvant radiotherapy seems to reduce the risk of local recurrence.

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THE NEGATIVE PRESSURE THERAPY IN THE TREATMENT OF THE OPEN ABDOMEN IS NOT CONTRAINDICATE IN THE PRESENCE OF INTESTINAL ANASTOMOSES

M. GIUSSANI, F. CANTORE, P. MOGLIA, M. ABUAWWAD, D. LOVOTTI, A. PIERINI, R. MACCHI, P.G. CAPRETTI

Azienda Ospedaliera Sant'Anna, Como, Italia

Objective: The Negative Pressure Therapy for surgical treatment complications or peritonitis is now established as a standard in damage control surgery. The benefit of this method is first of all the possibility to maintain the abdomen as clean as possible significantly reducing the bacterial load; the continuous negative pressure also ensures a lower fascial retraction than the simple laparotomy. The negative pressure is however not recommended in the presence of anastomosis for potential action favoring the development of fistulas and anastomotic dehiscence.
Methods: We report here our preliminary experience in the treatment of patients with diffuse peritonitis from intestinal ileal perforation treated with open abdomen and placing of VAC ® Therapy (KCI) and pack entero-entero anastomosis once they reach a suitable peritoneal toilet. In three patients the V.A.C. therapy has been in place from 3 to 14 days prior to package the entero-entero anastomosis. In two of the three patients the final closure of the abdomen, due to a considerable loss of substance, has been reached in a progressive manner by reducing the area of affixing the dressing aspiration getting the formation of a "controlled laparocele" while in one case it was possible obtain for a good fascial synthesis. The negative pressure was maintained at values of 75 mmHg.
Results: In our experience we found the safety and efficacy of VAC therapy in the presence of entero-entero anastomosis; during changes of programmed dressings there is also the possibility to monitor the viability and status of the intestinal loops.
Conclusions: We believe that negative pressure is a very useful method for treatment of diffuse peritonitis allowing a toilet almost continuous to the abdomen and a significant reduction of the bacterial load intraperitoneal, the presence of intestinal anastomosis does not contraindicate such treatment.

VAC-THERAPY MANAGEMENT OF LARGE NECROSIS OF THE ABDOMINAL WALL IN PRESENCE OF EXPOSED BIOLOGICAL MESH IN MULTIDRUG RESISTANT KPC POSITIVE PATIENT: A CASE REPORT

G. CURLETTI, L. REGGIANI, M. CERIOTTI, A. PERCIVALE, F. MARIANI, G. SACCOMANI

S.C. Chirurgia Generale, Ospedale Santa Corona, Pietra Ligure, Italia

We present the history of a patient (R.F.) who underwent Hartmann's colectomy for acute perforated diverticulitis. After surgery he presented sepsis by Straeptococcus spp whith cardiac rheumatic disease and septic embolizzation of the CNS followed by emiplegy and acute aortic insufficience that required an urgent cardiovascular surgery. After that, he was re-hospitalized to undergo ricanalizzation (the patient had pshicological discomfort whit the stoma) and repair of the incisional hernia (we used a biological mesh); two days after surgery he developed a recurrence of the incisional hernia. We have performed an immediate repair of the hernia but after few days he developed abdominal compartimental syndrome, that required relaparotomy and packaging of ileostomy. In the post-operative time compared extended necrosis of addominal wall and multi-drug resistant KPC colonization. He underwent to necrosectomy whit complete exposition of Permacol mesh and application of VAC therapy (it's management was difficult because the presence of ileostomy). There was a progressive improvement of the wound, colonization of the mesh and final closure of the skin. The patient will undergo shortly to closure of the ileostomy.

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NEOADJUVANT CHEMOTHERAPY IN LOCALLY ADVANCED GASTRIC CANCER: WHAT TO AVOID. PRELIMINARY ANALYSIS OF A CONSECUTIVE SERIES OF PATIENTS

L. RUSPI[1], S. RAUSEI[1], F. GALLI[1], G. LIANOS[2], I. PROSERPIO[3], F. FRATTINI[1], F. ROVERA[1], L. BONI[1], A. MANGANO[1], D.H. ROUKOS[2], G. PINOTTI[3], G. DIONIGI[1]

[1] Department of Surgery, University of Insubria, Varese, Italia
[2] Department of Surgery, University of Ioannina, Ioannina, Grecia
[3] Department of Oncology, University of Insubria, Varese, Italia

Objective: The role of NAD-CHT in patients with LAGC is validated. However, some important limitations emerged from the literature: patients selection, quality of surgery and pathological response evaluation. Neoadjuvant (NAD) chemotherapy (CHT) for locally advanced gastric cancer (LAGC) have been evaluated with a focus on safety and efficacy of the preoperative approach in terms of patients compliance, surgical outcomes, and pathological response.
Methods: Ninety-one patients with gastric adenocarcinoma were prospectively observed. All patients received CT scan and laparoscopy staging. Ten patients with LAGC (included 2 with LAGC suspected for cM+/lapM+) have been recruited in the preoperative ECF/EOX CHT protocol and were compared with 61 patients who underwent surgery alone.
Results: The overall compliance for preoperative CHT group was higher than compliance for adjuvant CHT observed in both NAD-CHT group and surgery alone group. There were two treatment shifts to FOLFOX in the preoperative regimen. In the preoperative CHT group D2-gastrectomy was possible only in 6/10 of cases with a R0 resection rate of 66·7% (versus 64·3% in the LAGC patients treated by surgery alone). The postoperative mortality and morbidity were 0% and 16·7% in NAD-CHT group versus 1·6% and 26·2% in surgery alone group. The overall pathological response rate after ND-CHT was 83·3% (5/6).
Conclusions: Staging and CHT management problems can negatively affect patients outcomes. In LAGC setting, when well applied, NAD-CHT could be considered a valuable treatment option.

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IMPACT OF SUPER-EXTENDED (D3) LYMPHADENECTOMY ON RELAPSE IN ADVANCED GASTRIC CANCER

M. BENCIVENGA[1], G. VERLATO[2], S. GIACOPUZZI[1], M.A. DI COSMO[1], C. CIPOLLARI[1], D. MARRELLI[3], F. ROVIELLO[3], G. DE MANZONI[1]

[1] Dept. of Surgery, Upper G.I. Surgery Division, University of Verona, Verona, Italy; [2] Unit of Epidemiology and Medical Statistics, Dept. of Public Health and Community Medicine, University of Verona, Verona, Italy; [3] Dept. of Human Pathology and Oncology, Section of General Surgery and Surgical Oncology, Translational Research Laboratory, University of Siena, Siena, Italy

Objective: Prophylactic D3 lymphadenectomy is no longer indicated in advanced gastric cancer (AGC), while the debate regarding the benefit of D3 lymphadenectomy when metastases to posterior nodal stations (12p-13-16) are clinically detected is still ongoing. The present study aimed at evaluating the impact of D3 lymphadenectomy on relapse of AGC patients when compared with D2 .
Methods: We retrospectively compared AGC patients undergoing D2 or D3 lymphadenectomy in the centres of Verona and Siena from 1992 to 2011. After excluding 20 Bormann IV tumours, 2 neuroendocrine tumours and 128 non-curative resections 574 subjects (276 D2 and 298 D3) were left for the analysis, none of them had received preoperative chemotherapy. Mantel-Haenszel test of homogeneity was used to verify whether the relation between extension of lymphadenectomy and relapse varied as a function of site, histology and T status. The impact of D2/D3 on relapse was further investigated by multivariable logistic regression model.
Results: Cumulative incidence of relapse was similar after D2 and after D3 both in the whole series (36.6% vs 41.3%; p=0.266). However, the association between relapse and extension of lymphadenectomy was significantly affected by histology (Mantel-Haenszel test of homogeneity: p=0.001). The risk of relapse was higher after D3 than after D2 (42% vs 26.9%; p=0.005) in the intestinal histotype while the pattern was reversed in the mixed/diffuse histotype (40.7% vs 52.4%; p=0.084). This pattern was confirmed in multivariable logistic regression: the interaction between histology and extension of lymphadenectomy was highly significant (p=0.001). In particular, cumulative incidence of local and nodal recurrences was higher in the diffuse histotype as expected after D2, while being higher in the intestinal histotype after D3.
Conclusions: D3 lymphadenectomy reverses the negative impact of diffuse histotype on relapses, especially on local and nodal recurrences, therefore it could be considered a valid therapeutic option in histotype-oriented tailored treatment of AGC.

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LAPAROSCOPIC RADICAL NEPHRECTOMY FOR LARGE RENAL CELL CARCINOMA: EXPERIENCE IN A SINGLE CENTER

A. AGRUSA, G. ROMANO, G. DI BUONO, G. FRAZZETTA, D. CHIANETTA, V. SORCE, L. GULOTTA, S. AMODEO, G. GULOTTA

Department of General Surgery, Urgency and Organ Transplantation, University of Palermo, Palermo, Italia

Objective: According to the European Association of Urology guidelines, Laparoscopic Radical Nephrectomy (LRN) is now the recommended standard of care for patients with T1/T2 renal cell carcinoma (RCC) not treatable by nephron-sparing surgery. The aim of this study is to evaluate the safety of LRN for RCC larger than 7 cm.
Methods: We performed a retrospective analysis in the period between January 2010 and May 2014 at General Surgery and Emergency Department of the University Hospital Policlinico "P. Giaccone" in Palermo. We selected 36 patients undergoing LRN with a RCC > 7 cm. We performed transperitoneal LRN and we used 3D laparoscopic technology too. Exclusion criteria for laparoscopic approach were presence of caval thrombus or vascular infiltration. The neoplastic involvement of adrenal gland or spleen is not considerated controindication to laparoscopic surgery.
Results: Median age was 59 years (range 37-81), BMI range was 22 – 49.5 kg/m^2. Median tumor size was 11.1 cm (range 7.5-15 cm). There were 21 left side tumors and 15 right side tumors. Mean operative time was 195 min (range 110 – 330 min). There was no significative intra-operative bleeding nor conversion to open surgery. Only a patients needed for blood transfusion because of wound hematoma. No other complication were recorded. Pathologic stage was from T2 to T3b. We resected 29 conventional tumors, 4 chromophobe, 1 sarcomatoid and 2 papillary.
Conclusions: This study shows that LRN for large renal cancer is a safe and effective procedure in experienced surgeon. Laparoscopy give good outcome with minimal complications and 3D vision influence surgeon performance with technique improvement and faster operative time than 2D vision The only size of renal tumor is not a contraindication to laparoscopic surgery.

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CARDIAC RESYNCHRONIZATION THERAPY: LEFT VENTRICULAR PACING LEAD VIDEOTHORACOSCOPIC IMPLANTATION

M.C. BOTTOLI[1], A. DROGHETTI[1], M. GIOVANARDI[1], P. PEPI[2], A. REGGIANI[2], G. MURIANA[1]

[1] Struttura Complessa di Chirurgia Toracica, AO Carlo Poma, Mantova, Italia
[2] SC di Cardiologia, AO Carlo Poma, Mantova, Italia

Objective: The transvenous placement of the left cardiac pacing leads is sometimes impossible for the absence of satisfactory venous access or unfavorable anatomy of the coronary sinus, unstable position or diaphragmatic twitch. The innovative positioning tool "FastacFlex®" allows epicardial anchoring by videothoracoscopy.
Methods: 83 patients underwent implantation of the left ventricular epicardial pacing lead.
Mean age was 63,4 years, EF was 26%, 50 (56%) patients had ischemic cardiomyopathy and all of them had NYHA functional class III±I.
All patients were evaluated with a low resolution CT scan before surgery to rule out any thoracopulmonary pathology. Then the following tests were performed: spirometry with DLCO; a complete clinical and functional evaluation (including a six minute walking test); electrocardiographic and echocardiographic examination.
All procedures were performed with 3 ports VTS (5 mm, 10 mm and 15 mm) on the left chest wall.
Results: The epicardial lead was successfully placed in all patients. The median procedure time was 34 minutes. Final measurements showed median threshold values of 1,14 V/0,5 ms. Neither complications nor dislocations were observed. The chest drainage was average removed after 12-24 hours. Median length of hospital stay was 4 days. Following removal of the drain a chest X-ray by two-orthogonal projections was performed in order to assess the final LV lead position.
Prior to hospital discharge, each patient underwent device programming optimization, a standard 12-lead ECG and an echocardiographic examination.
All pacing parameters remained stable over time. Left Ventricle (LV) Ejection Fraction improved from an average of 26% to 42%. All patients reported an improvement in NYHA function class, with a significant improvement in quality of life and a significant increase in exercise tolerance.
Conclusions: The VTS placement of the epicardial pacing lead is safe, feasible and efficacious with comparable DFTs with conventional transvenous implant.

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TOPOGRAPHY OF LUNG METASTASES: A SINGLE INSTITUTION REVIEW OF THE LAST DECADE

N.P. ARDÒ[1], D. LOIZZI[1], A. DE PALMA[2], S. TANGO[2], F. SOLLITTO[1]

[1] Sezione e S.C. Chirurgia Toracica, Università di Foggia, Dipartimento di Scienze Mediche e Chirurgiche. Ospedali Riuniti di Foggia, Foggia, Italia; [2] Sezione e S.C. Chirurgia Toracica, Università degli Studi di Bari 'Aldo Moro', Dip. Emergenze e Trapianti d'Organo. Ospedale Policlinico Bari, Bari, Italia

Objective: An observational study about lung metastases' topography is presented. The main objective is to find a statistical correlation between: 1) primitive tumor site and single or multiple lung metastases; 2) primitive tumor site and the pulmonary lobe interested by metastatic disease.
The secondary aim is to assess for each primitive tumor site, in patients with metastatic relapse, if the disease interests the same or another pulmonary lobe.
Methods: The study reviewed all the cases of lung metastases consecutively observed at the same institution and histologically confirmed. From 01/01/2004 to 28/02/2014 we observed 116 cases of lung metastases in 91 patients with a mean age of 63 years (range 31-90); the ratio male/female was 1,32. The primitive tumor site was: bowel (54 cases), breast (18), bladder (8), uterus (8), larynx (6), kidney (5), ovary (5), skin (4 melanoma), thyroid (2), parotid (2), testis (1), tongue (1), soft tissue (1 malignant fibrous histiocytoma), nasopharynx (1). The operations on the lung were: pneumonectomy (1), bilobectomy (1), lobectomy (12), wedge resection (100), lung needle biopsy (2). In 7 patients we observed 11 lung metastatic relapses from: bowel (9), larynx (1), uterus (1). The statistical study was carried out by chi-square test.
Results: A statistically significant relationship between the primitive tumor site and the presence of single or multiple lung metastases was not observed (p=0,5).
There was no statistically significant relationship between the primitive tumor site and the lung lobe interested by metastatic disease (p=0,79).
If considering the single metastases instead of the single patients, the relationship become significant (p=0,0078).
The lung metastasis recurrences of bowel tumors interested the same lung lobe in the 66% of the cases. The larynx tumor relapsed in the same lung lobe (1 patient, 100%). The uterus tumor relapsed in a different lung lobe (1 patient, 100%).
Conclusions: The presence of single or multiple lung metastasis does not depend on the primitive tumor site, but probably on the tumor stage or the histological grading. The tropism of some organs (as primitive tumor site) for specific lung lobes seems not to be casual. Bowel tumors have a tendency to make metastatic recurrences in the same lung lobe. The esigual number of metastatic recurrences cases from the others tumor sites (uterus and larynx) does not allow conclusions to be drown.

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FACIAL PARALYSIS AND CHOLESTEATOMA SURGERY

G. IANNELLA, R. VALPEGA DI MASINO, A. DE VIRGILIO, G. MAGLIULO

Dipartimento Organi di Senso, Università degli Studi di Roma "Sapienza", Roma, Italia

Objective: Aim of the study was investigate the existence of an intraoperative Fallopian canal dehiscences in patients affected by cholesteatoma and petrous bone cholesteatoma in order to assess the risk of encountering an unprotected facial nerve during routine ear surgery with consequent possibility of facial paralysis. Preoperative and postoperative facial paralysis were also analyzed. Finally we evaluated the efficacy of CT studies in showing Fallopian canal dehiscences.
Methods: 336 patients primary cholesteatoma and 57 patients with petrous bone cholesteatoma undergoing tympanoplasty with mastoidectomy with bone dehiscence intraoperatively observed. Preoperative and postoperative facial paralysis were evaluated by House-Brackmann scale.
Results: 45.7 percent of the patients with primary cholesteatoma had an intraoperative dehiscence of the Fallopian canal. No postoperative paralysis were observed. 4 preoperative facial paralysis were observed of which, postoperative facial function at one year follow-up was in 2 cases grade I, in 1 case grade II, and in the last 1 case grade IV of the House-Brackmann scale evaluation. 54.4 percent of patients with petrous bone cholesteatoma had preoperative facial paralysis of which 19 with grade VI of the House-Brackmann scale evaluation. Postoperative facial paralysis was seen in 59.7% of cases.
Conclusions: Cholesteatoma duration and extension are related to the possibility of the fallopian canal dehiscences. Dehiscence are more frequent in the tympanic segment. The risk of postoperative facial paralysis is however low in case of successful execution of the surgical technique. Preoperative CT does not provide a good indication about the presence of dehiscence. High incidence of preoperative and postoperative facial paralysis in cases of petrous bone cholesteatoma were observed.

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TREATMENT OF TRACHEAL TUMORS: OUR EXPERIENCE

M. LORUSSO[1], A. DE PALMA[1], F. DI GENNARO[1], M. BITETTO[1], D. SCARASCIA[1], D. LOIZZI[2], M. LOIZZI[1]

[1] Sezione di Chirurgia Toracica, Università degli Studi di Bari "Aldo Moro", Bari, Italia
[2] Sezione di Chirurgia Toracica, Università degli Studi di Foggia, Foggia, Italia

Objective: Tracheal tumors are rare neoplasms with extremely heterogeneous histological aspects. We report the results of our experience in conservative, endoscopic and surgical treatment of primary and secondary tracheal tumors.
Methods: From January 2008 to April 2014 we observed 6 patients (2 males, 4 females) affected by tracheal tumors: 5 primary (1 squamous carcinoma, 1 inflammatory pseudotumor, 1 subglottic hemangioma, 1 condromatous hamartoma, 1 minor salivary gland acinic cell carcinoma), 1 secondary (pulmonary adenocarcinoma). Median age was 50,5 years (range: 2 months-72 years). Treatments were as follows: conservative in 1 case (subglottic hemangioma, successfully treated with propranolol); endoscopic in 2 cases (1 squamous carcinoma resected with Nd-YAG laser and biopsy forceps; 1 metastasis from pulmonary adenocarcinoma resected with coring, Nd-YAG laser and biopsy forceps); surgical in 3 cases (1 inflammatory pseudotumor, at first endoscopically resected and then, for a rapid tendency to recurrence and transmural involvement, excised by termino-terminal tracheal anastomosis through cervicotomy; 1 condromatous hamartoma, removed by termino-terminal tracheal anastomosis through cervicotomy, under sedation and local anesthesia; 1 minor salivary gland acinic cell carcinoma, in a patient who already underwent resection of tracheal pleomorphic adenoma, removed by transcervical-transtracheal approach through re-cervicotomy).
Results: Post-treatment course was uneventful and with radical results in all patients. At a median follow-up of 28 months (range: 1-76 months), no recurrences have been observed.
Conclusions: Treatment of tracheal tumors may vary in relationship to patient clinical condition, grade of tracheal obstruction, extension, histology and biological behaviour of the tumor, which are factors affecting prognosis and survival. Endoscopical evaluation and histological diagnosis are mandatory to select the most adequate treatment; whenever possible, radical surgical resection should be performed.

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SURGICAL TREATMENT OF MEDIASTINAL BRONCHOGENIC CYSTS: OUR EXPERIENCE

M. BITETTO, A. DE PALMA, D. SCARASCIA, M. LORUSSO, F. DI GENNARO, R. QUERCIA, M. LOIZZI

Sezione di Chirurgia Toracica, Università degli Studi di Bari "Aldo Moro", Bari, Italia

Objective: Bronchogenic cysts are localized portions of the tracheo-bronchial tree which abnormally separate from the normal airways during the ramification process; 75-85% of cysts develops in the mediastinum, 15-25% in the lung. They can be asymptomatic or give compression (airways, heart and big vessels) or suppuration symptoms. We report the results of our experience in surgical treatment of this rare benign disease with mediastinal location, which however in some cases may cause a severe endangerment of the clinical condition of patients.
Methods: From 2009 to 2014 we observed and treated 6 patients, 5 females and 1 male (median age: 41 years; range: 8-71 years), with chest CT and/or MRI scan detection of a mediastinal bronchogenic cyst, with round margins, fluid content and regular borders. One patient had already undergone surgery with partial resection of the cyst through left thoracotomy. In all cases pre-operative evaluation was performed with spirometry, arterial blood gas (ABG), electrocardiography (ECG) and echocardiography, to precisely determine the impact of the cyst on cardio-respiratory function.
All surgical operations were performed through a lateral thoracotomy (4 right, 2 left) at the fifth intercostal space and the cysts completely excised, after isolation, section and suture of the pedunculum.
Results: Median operating time was 140 minutes (range: 105-450 minutes). Post-operative course was uneventful and the pathological examination confirmed the radical excision of all the mediastinal bronchogenic cysts. Median post-operative hospital stay was 7 days (range: 6-8 days). Ad a median follow-up of 19 months (range: 4-64 months) no patient presents recurrence of the disease.
Conclusions: Though rare, bronchogenic mediastinal cysts can endanger patients life because of volume growth and consequent compression symptoms on vital structures. After radical resection prognosis is good, allowing definitive recovery of the disease.

LAPAROSCOPY IN ACUTE ABDOMEN IN PEDIATRIC SURGERY: A 5-YEAR EXPERIENCE

G. DI NAPOLI, C. MAGGIPINTO, M. D'AMATO, G. PARADIES

Azienda Ospedaliera Universitaria Consorziale Policlinico, Bari, Ospedale Pediatrico "Giovanni XXIII" U.O.C. Chirurgia Pediatrica Direttore: Dr. G. Paradies, Bari, Italia

Objective: Minimal invasive surgery had a considerable impact on common surgical techniques and has almost replaced established operative procedures. The child with an acute abdomen presents the perfect opportunity to take advantage of the benefits of MIS. Currently, emergency laparoscopic surgery for acute abdominal conditions has become the favored surgical approach; therefore, we investigated the diagnostic accuracy and therapeutic efficacy of laparoscopy in acute abdominal pain in our clinic over a period of 5 years.
Methods: There are a wide variety of conditions, acquired and congenital, for which MIS provide the distinct advantages of a cost-effective diagnosis and therapy with minimal discomfort for the patient. From July 2009 to June 2014 we perfomed 1186 MIS in children aged between 3 months and 17 years with acute abdomen: 992 appendectomies, 4 intussusception, 9 Meckel's diverticulum, 100 abdominal adhesions, 11 abdominal abscess, 45 annexial pathology, 16 cholecystectomies.
Results: The outcome data showed difference in days of hospitalization after intervention, in antibiotic and analgesic requirement and reduction of pain. Our experience accomplish that MIS in diagnosis and treatment in the acute abdomen is a simple, safe and effective process.
Conclusions: The outcomes of these studies strongly suggest that primary laparoscopic surgery for emergency conditions provides excellent results, including better exposure and cosmetic outcomes that laparotomy. Laparoscopy can be used in the diagnosis and treatment of patients with suspected acute abdomen that imitates acute appendicitis and cannot be differentiated with physical examination and laboratory methods.

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DIAGNOSTIC VALUE OF LYMPH NODE SURGICAL BIOPSY IN HEMATOLOGICAL DISEASE. A STUDY OF 329 CASES

D. SORIERO, S. SCABINI, A. MASSOBRIO, L. DE MARINI, E. ROMAIRONE

Chirurgia Oncologica, IRCCS Azienda Ospedaliera Universitaria San Martino-Ist, Genova, Italia

Background: To evaluate the diagnostic value of lymph node surgical biopsy in hematologic diseases.
Materials and methods: A retrospective analysis of 329 consecutive patients was analyzed between 2005 and 2014. We took into account the personal history (age, gender, history of cancer, chronic disease), type of surgical approach (site of the biopsy, operating time, anesthesia, type of biopsy) and characteristics of specimen (number and size of nodes, role of pathologist). If the diagnosis was free-tumor we studied the following radiological and blood exams to find eventual unrecognized disease.
Results: Of the 329 cases, 326 were suitable for pathological exam; of the 326, 15 were without diagnosis (only descriptive reports), 255 were diagnosed with tumor and 56 were free-tumor. 10 cases of free-tumor diagnosis developed cancer in later months. In one case we had to perform an additional biopsy.
Conclusions: Lymph node surgical biopsy is a process with high diagnostic index. According to our experience it reaches 94,53% accuracy. This value can be improved by encouraging a clinical-radiological consultation with several specialist.

FIRST REPORT OF HAND ULCER WITH CITROBACTERKOSERI INFECTION IN AN IMMUNOCOMPETENT PATIENT

F. SOMMA, E. CIGNA, J. KACIULYTE, N. SCUDERI

Università degli Studi di Roma "Sapienza", Policlinico Umberto I, Roma, Italia

Citrobacter Koseri is a Gram-negative bacteria known to cause infections in premature newborns or immunocompromised patients. We present the case of an adult immunocompetent patient, in which *C. Koseri* caused an infection of the left hand that lead to a wide necrosis of the soft tissues.
Complete recovery was reached thanks to targeted antibiotic therapy, surgical debridement and VAC Therapy Ulta®.
Citrobacter Koseri is emerging as a possible cause of community acquired infection also in immunocompetent patients: it is possible to find those cases in literature. Still, our case represents the first report of *C. Koseri* necrotic-ulcerative infection of the hand, not related to trauma, in an immunocompetent patient.

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CONGENITAL ABSENCE OF THE LEFT HALF OF THE DIAPHRAGM MIMICKING A DIAPHRAGMATIC HERNIA IN AN ELDER: A CASE OF ACUTE BOWEL OBSTRUCTION AND DYSPNEA

V. FERRARO, A. GURRADO, S. GIUNGATO, S. LAFRANCESCHINA, R. ROMITO, E. CEA, G. PICCINNI, M. TESTINI

Dipartimento di Scienze Biomediche ed Oncologia Umana, Università degli studi di Bari, Bari, Italia

Objective: Multiple abnormalities of the embryologic development are involved in many congenital syndromes, which are not all known yet.
Methods: A 63 years old woman was admitted in emergency at our Academic Department of General Surgery, due to bowel obstruction and dyspnoea. Anamnesis revealed chronic abdominal pain, mental retardation and strabismus. CT scan showed a left diaphragmatic defect, with herniation into the chest cavity of massive dilated transverse and descending colon with homolateral pulmonary atelectasis. The patient underwent emergency surgery, and a left diaphragm agenesis, megacolon and left liver agenesis were found. An intraoperative bronchoscopy revealed some abnormalities of the bronchi and a concomitant hypoplasia of the left lung.
Results: A subtotal colectomy with a termino-terminal ileo-rectal anastomosis was performed. Postoperative course was uneventful. Histology demonstrated a marked hyperplasia of the muscularis mucosae of the colon and the cytoplasmic vacuolation of the ganglia. The research of abnormalities of the karyotype, phenotype and genetic pattern was negative for what concerns all the known congenital syndromes.
Conclusions: We suppose that the association of strabismus and mental retardation with the agenesis of the left diaphragm, left liver and left bronchial tree, could be derived from the same abnormality of the embryologic development. Further researches should be performed in order to define the sporadic or syndromic source of these multiorgan abnormalities.

JEJUNAL OVEREXPRESSION OF PYY IN CELIAC DISEASE COMPLICATED WITH PNEUMATOSIS CYSTOIDES INTESTINALIS

A. DE LUCA, A. GURRADO, S. GIUNGATO, A. GIRARDI, A. PASCULLI, V.M.L. PANUNZIO, T. SEGRETO, G. PICCINNI, M. TESTINI

Dipartimento di Scienze Biomediche ed Oncologia Umana, Università degli Studi di Bari, Bari, Italia

Objective: Pneumatosis cystoides intestinalis (PCI) is an uncommon condition, more frequently associated to pathologic conditions, such as celiac disease (CD). Peptide-YY (PYY) is an anorectic neurohormonal factor, synthesized and released within the distal small bowel and colon from specialized enteroendocrine cells. We present the case of an isolated immunohistochemical overexpression of PYY in jejunum affected by PCI in a patient treated with gluten-free diet for CD.
Methods: A 61-year old celiac man was admitted to our Academic Department for bowel obstruction, abdominal pain and distention without irritative peritoneal signs. Despite the gluten-free diet, the patient referred chronic inappetence, weight loss, malabsorption, and diarrhoea. CT scan showed sub-diaphragmatical free-air and small bowel pneumatosis. At the surgery, distended jejunal loops with wall air cysts and without macroscopic perforation were found at 60 cm distance from Treitz ligament, and a resection of 150 cm of jejunum and a side to side jejuno-ileal anastomosis were performed. Postoperative course was uneventful.
Results: Immunohistochemistry showed a localized overexpression of PYY into the jejunal tract affected by PCI.
Conclusions: The systematic review revealed that the overexpression of PYY in jejunal segment affected by PCI resulting from CD is inedited. We hypothesize that in this case the CD and PCI were correlated as previously demonstrated, but that inappetence, weight loss and chronic malabsorption symptoms were only resulting from the jejunal overexpression of PYY. Although the gluten-free diet was continuously carried out by the patient, indeed, the resolution of the chronic clinical picture was obtained only by means surgery.

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ELASTOFIBROMA DORSI: OUR EXPERIENCE IN SURGICAL TREATMENT ON A SERIES OF THE LAST 6 YEARS

D. SCARASCIA, A. DE PALMA, M. BITETTO, F. DI GENNARO, M. LORUSSO, R. QUERCIA, M. LOIZZI

Sezione di Chirurgia Toracica, Università degli Studi di Bari "Aldo Moro", Bari, Italia

Objective: Elastofibroma dorsi, though rare, represent an important part of the experience of young thoracic surgeons, both for the frequency of the disease in thoracic surgery departments and for the limitations of motility it can cause on patients daily life. We report the results of our experience in surgical resection of elastofibroma dorsi, with the objective of optimizing patients treatment, thus obtaining a faster return to normal daily work and domestic activities.
Methods: From March 2008 to March 2014, 26 patients (median age 56 years, range: 40-70 years), have been treated at our Institution for surgical resection of elastofibroma dorsi. At the onset, the disease was unilateral in 61.5% (n=16) and bilateral in 38.5% of cases (n=10). In all patients the diagnosis was clinical and most of them were submitted to pre-operative study with echography of the involved dorsal region and/or chest MRI and/or CT scan to precisely evaluate the site and characteristics of the lesion.
Results: The lesion was macroscopically radically excised in all patients, however, at pathological examination, surgical margins were free from disease in none of them. Median operating time was 60 minutes (range: 55-90 minutes), without intra-operative complications. Median post-operative hospital stay was 4 days (range: 3-6 days). Twenty-two patients (84.6%) had no post-operative complications, minor complications occurred in 4 (15.4%). Median drainage time was 2 days (range 2-4 days) and median time to return to normal daily activities was 30 days (range 20-40 days). At a median follow-up of 28 months (range: 2-72 months), no patient presents pain, motility limitations or recurrence of the disease.
Conclusions: In our experience, patients submitted to resection of elastofibroma dorsi showed no significant post-operative complications, short hospital stay and fast return to normal daily activities. Moreover, no pain, motility limitations and local recurrences were present at long term follow-up.

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THE "ITALIAN JOB" IN SPAIN. HIGH QUALITY SURGICAL EXPERIENCE

B. IELPO, M.G. DE LUCA, R. CARUSO, A. PRESTERA, H. DURAN, E. DIAZ, I. FABRA, C. OLIVA, S. OLIVARES, Y. QUIJANO, E. VICENTE

Centro Oncológico "Clara Campal" Servicio de Cirugía General y Digestiva Madrid, Hospital Universitario Madrid Norte Sanchinarro, Madrid, Spagna

Objective: Foreign surgical experience during residency is essential for a complete training. Most of these are in UK (20%), USA (18%) and France (11%). However, in the last years, there is a saturation especially of italian fellows in UK and France that may deteriorate the quality of this experience. There are also other potential places where perform this experience, like Spain that has a high quality surgical training of their own residents. Aim of this essay is to present a single spanish center experience concerning foreign surgical fellows, focusing especially on Italians.
Methods: Sanchinarro universitary hospital is in Madrid. General surgical department has 4 surgery rooms per day with a total of 2000 mean surgeries per year. Almost 90% of these are for oncological disease and a mean of 65% of these are perfomed by a minimally invasive approach (both laparoscopic and robotic).
Results: The number of foreign doctors that have been visiting our center is 35 with a mean period of time of 5 months (range:1-12). Italian fellow at our center from 2012 to 2014 have been 6 (3 resident, 1 surgeon and 2 medical students).They have performed as first surgeon a mean of 7 and 3 of low and moderate complex procedures per month, respectively. Furthermore, they have been assistent surgeon in high complex procedures like pancreatectomy, hepatectomy (open and minimally invasive) in a mean of 3 per month. They have been included in 15 indexed international scientific publications as well as in 46 international surgical congress abstracts. Four of these italians developed their universitary thesis at our center. One of theme that finished its residency few months ago is actually working as staff at our center.
Conclusions: Spain and especially this center can be and adequate alternative where performe a complete foreign surgical experience.

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EGFR MUTATION ANALYSIS IN NSCLC

F. TOTA[1], M.I. NATALICCHIO[2], D. LOIZZI[3], N.P. ARDÒ[3], R. DE BELLIS[4], F. SOLLITTO[1]

[1] Sezione e U.O. di Chirurgia Toracica, Università di Foggia, Dipartimento di Scienze Mediche e Chirurgiche. Ospedali Riuniti di Foggia, Foggia, Italia; [2] Laboratorio di Oncologia Molecolare dei tumori solidi e Farmacogenomica, Ospedali Riuniti di Foggia, Dipartimento di Patologica Clinica, Foggia, Italia; [3] Sezione e S.C. Chirurgia Toracica, Università di Foggia, Dipartimento di Scienze Mediche e Chirurgiche. Ospedali Riuniti di Foggia, Foggia, Italia; [4] Sezione e S.C. Chirurgia Toracica, Università degli Studi di Bari "Aldo Moro", Dip. Emergenze e Trapianti d'Organo. Ospedale Policlinico Bari., Bari, Italia

Objective: The discovery of somatic mutations in the tyrosine kinase (TK) domain of EGFR (epidermal growth factor receptor) is an effective treatment strategy in non-small-cell-lung cancer (NSCLC) advanced disease.
The EGFR gene is located on the short arm of chromosome 7, which is commonly amplified in NSCLC. The mutations of EGFR permit therapy with TK inhibitors (TKIs). Mutations in the kinase domain of EGFR have been associated with an acquired resistance to TKIs.
In wtEGFR (wild type EGFR), KRAS mutations finding has a negative prognostic value.
We report: a) frequency and typology of EGFR-mutations in our patients, b) distributions in male and female patients, c) molecular pathway of KRAS in wtEGFR patients.
Methods: We analysed mutational status of 82 Caucasian patients (59 men, 23 women) submitted to thoracic surgery procedures at our Institution from genuary 2011 to june 2014. Histology revealed adenocarcinoma (n=68), mixed adenocarcinoma (n=6), poorly differentiated lung carcinoma (n=2).
EGFR-mutations were detected by sequencing the PCR-amplified exon sequences of tumoral tissue. Mutations of KRAS gene were detected in 18 wtEGFR patients.
Results: In 82 patients, 70 were wild type; 12 patients (14.63%; 5 males, 7 female) revealed mutations of EGFR gene (7 deletions in exon 19, 3 point mutations in exon 21, 2 resistance mutations in exon 20-type S768 and T790M respectively). In 18 wtEGFR patients the analysis of KRAS gene showed 9 wt and 9 mutated types (3 G12D, 3 G12C, 2 G12V, 1 Q61H respectively).
Conclusions: IPASS study proved that EGFR mutations prevail in female, never smoker, East Asian patients with adenocarcinoma. In agreement with literature, our review revealed an overall prevalence of EGFR mutations concordant with the 5-20% attested percentage in Caucasian patients, and a higher distribution in female (30%) versus male patients (8,47%).

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POSSIBLE ROLE OF LOW MAGNESIUM SERUM LEVELS IN THE ONSET OF POSTOPERATIVE HYPOCALCAEMIA IN PATIENTS UNDERGOING THYROID SURGERY

E. VARALDO[1], G.L. ANSALDO[1], M. MASCHERINI[1], G. BARGETTO[1], M. PUGLISI[1], F. CAFIERO[1], G. SANTORI[2], M. MINUTO[1]

[1] UOC Chirurgia 1, IRCCS AOU San Martino IST, Genova, Italia
[2] Dipartimento di Scienze Chirurgiche, Università degli Studi di Genova, Genova, Italia

Objective: A positive correlation between serum calcium and magnesium levels is well known and depends upon different factors. We hypothesized that magnesium might play a role in the onset of hypocalcaemia in patients undergoing thyroid surgery. This study aims at verifying the existence of an association between hypomagnesaemia and hypocalcaemia in a retrospective series of patients who underwent thyroid surgery in a tertiary care referral center for the treatment of thyroid diseases.
Methods: From 2012 to 2014, 285 consecutive patients (202F, 83M, mean age 57 years, range: 20-87) who underwent a total thyroidectomy, and had a complete clinical and biochemical pre- and postoperative evaluation were included in the study. Patients underwent surgery for a hyperthyroid disease in 65 patients (23%), whereas in all other cases they were euthyroid. Two-hundred and 23 patients underwent a total thyroidectomy (TT, 78%), 54 underwent TT and central neck dissection (19%), 8 patients underwent bilateral completion surgery (3%). Hypocalcaemia was evaluated with regard to the following parameters: sex, age, indications for surgery, number of parathyroids intraoperatively identified, extent and time of surgery, presence of thyroiditis, final histology, pre- and postoperative levels of calcium, magnesium, and creatinine, presence of symptoms of hypocalcaemia. The statistical analysis has been performed using the "R" software, version 3.1.0.
Results: At surgery, less than 4 parathyroids were identified in 12 cases (4%). In the postoperative period, a biochemical hypocalcaemia was evident in 126 patients (44%), 68 of whom displayed symptoms (24%). The factors significantly associated with postoperative hypocalcaemia were: older age ($p=0.019$), longer operative time ($p=0.039$), and lower magnesium levels ($p<0.001$).
Conclusions: Many well-known factors can significantly affect the onset of postoperative hypocalcaemia in patients undergoing thyroid surgery. This retrospective study confirms that a low postoperative magnesium level seems to be associated with hypocalcaemia in patients undergoing thyroid surgery.

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EARLY INTACT PTH (IPTH) IS AN EARLY PREDICTOR OF POSTOPERATIVE HYPOCALCEMIA FOR A SAFER AND EARLIER HOSPITAL DISCHARGE: AN ANALYSIS ON 260 TOTAL THYROIDECTOMIES

D. INVERSINI, S. RAUSEI, F. FRATTINI, M. LAVAZZA, A. MANGANO, F. ROVERA, L. BONI, G. DIONIGI

Department of Surgery, University of Insubria, Varese, Italia

Objective: Hypocalcemia is the most frequent complication after thyroidectomy. Serum calcium levels are reliable only 48-72 hours postoperatively. iPTH has been proposed as early predictor of postoperatory hypocalcemia. Our aim is to assess the ability of iPTH in predicting postoperative hypocalcemia.
Methods: 260 patients underwent thyroidectomy with postoperative iPTH evaluation. The iPTH samplings were early performed after thyroidectomy. The calcium levels were dosed postoperatively. Age, sex, type of diagnosis, obesity, comorbidities, previous neck surgery, preoperative therapy, type of surgery, dissectors used, lateral lymphadenectomy of the central compartment, post-operative complications, reoperation and histological type were considered. The primary end-point was the postoperative hospital stay. The secondary end-points were serum calcium and iPTH. Three iPTH cut-off were tested to assess which was the best value among those reported in the literature (10.0-15.0-20.0 pg / mL).
Results: The iPTH cut-off value of 10.0 pg/mL was the most accurate and specific. Comparing the iPTH value with the different values of calcium respectively 24 and 48 hours after surgery, a statistically stronger association with the serum calcium levels 48 hours postoperativelyhas been shown.
Conclusions: The correlation of iPTH with symptoms of hypocalcemia is significant since a few hours after surgery and the value of iPTH ≥ 10 pg/mL, is able to select those patients for a safe and early discharge. iPTH ≥ 10 pg/mL 3-6 hours after surgery was strongly correlated to early discharge. The use of the iPTH may avoid unnecessary extensions of hospitalization.

RECURRENT LARYNGEAL NERVE INJURY: A COMPLEX PATIENT MANAGEMENT

C.C. FERRARI, S. RAUSEI, F. ROVERA, A. LEOTTA, A. MANGANO, M. LAVAZZA, D. INVERSINI, S. SPAMPATTI, F. FRATTINI, M. ANNONI, L. BONI, G. DIONIGI

Department of Surgery, University of Insubria, Varese, Italia

Background: Recurrent Laryngeal Nerve (RLN) palsy represents one of the most frequent complications after thyroid surgery. To avoid this kind of injury is of primary importance and abundant literature analyse different techniques, new devices and surgical strategies to minimize RLN lesion incidence. Aim was to assess the resources consumption in patient with RLN injury management versus non-injured patient management. Three perspectives were investigated: patient, National Healthcare System (NHS) and society.
Methods: Direct and indirect costs in RLN injury management were estimated. The analysis was based on standardized clinical pathways and analysis of injured patient care process. The analysis includes costs associated with hospitalizations, medications, diagnostic tests, outpatient visits, rehabilitation, general practitioner visits. Five scenarios were identified, based on the result of the RLN injury with vocal fold paralysis: vocal folds function recovery within one, three and six months (first, second and third scenarios respectively) and vocal fold permanent paralysis after six months until one year without and with phonosurgery (scenario four and five respectively). Based on the specific exemption code, direct costs were valued from the NHS and patient perspectives. From the societal perspective, indirect costs were valued in terms of productivity loss (Human Capital Approach).
Results: From the patient perspective, the mean increment is constant in every scenario (€17,25); from NHS perspective, the analysis shows a significant increase, from a minimum of €70,43 (first scenario) to a maximum of €3.112,8 in the case of permanent paralysis with phonosurgery. Productivity losses were accounted for €156 per day per patient.
Conclusions: The analysis shows a significant economic impact of RLN injury management.

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INTRAOPERATIVE NERVE MONITORING (IONM) OF RECURRENT LARYNGEAL NERVE. COMPARISON BETWEEN THYROIDECTOMY WITHOUT IONM, WITH INTERMITTENT (I-IONM) AND WITH CONTINUOUS NEUROMONITORING (C-IONM)

M. LAVAZZA, S. RAUSEI, F. ROVERA, A. LEOTTA, C.C. FERRARI, A. MANGANO, D. INVERSINI, S. SPAMPATTI, F. FRATTINI, M. ANNONI, L. BONI, G. DIONIGI

Department of Surgery, University of Insubria, Varese, Italia

Objective: To compare the intermittent neuromonitoring (I-IONM) and the continuous (C-IONM) for the protection of the recurrent laryngeal nerve during thyroidectomy.
Methods: Since 2006 the I-IONM has been regularly applied in thyroid surgery; in 2009 it has been used in a standardized way (V1, R1, V2, R2) and in 2013 the C-IONM was introduced as additional support for the thyroidectomy. Rates of vocal cord paralysis (VCP) and the corresponding IONM signals of both methods were prospectively compared. IONM has not been applied in 870 nerves at risk (NAR). IONM without standardization has been used in 198 NAR, in 1176 nerves was used in a standardized way and the C-IONM on 386 nerves.
Results: A VCP was diagnosed in 5.9% using the non-IONM (4.9% transient, permanent 1%); 5.7% in non-standardized IONM (5.1% transient, permanent 0.6%); 4.7% in standardized IONM (3.9% transient, 0.8 % permanent) and 2.8% in the C-IONM (0% permanent). The C-IONM has allowed us to highlight the most dangerous moments for the loss of signal, that were identified in: medial traction of the thyroid gland, dissection of the lower pole, of the ligament of Berry, or of the inferior thyroid artery's branches. The intraoperative modification of the surgical act has resulted in the recovery of the EMG signal in the 63% of the cases with the C-IONM (19/30 NAR). The recognition of the surgical maneuver is significantly better for C-IONM vs. I-IONM (63 vs. 24%, p=0.0008).
Conclusions: The C-IONM method reduces the rates of VCP. Continuous control of the signals during the various stages of the dissection reduces irreversible damage of the nerve and allows the surgeon to pay more attention to the functioning of the nerve.

EXPERIMENTAL STUDY ON THE SAFE USE OF LIGASURE SMALL JAW (LSJ) NEXT TO THE RECURRENT LARYNGEAL NERVE (RLN)

S. SPAMPATTI[1], S. RAUSEI[1], A. LEOTTA[1], F. ROVERA[1], C.C. FERRARI[1], M. LAVAZZA[1], D. INVERSINI[1], FENG-YU CHIANG[2], CHE WEI WU[2], HOOB YU KIM[3], F. FRATTINI[1], A. MANGANO[1], M. ANNONI[1], L. BONI[1], G. DIONIGI[1]

[1] Department of Surgery, University of Insubria, Varese, Italia
[2] Department of Otolaryngology, Kaohsiung Medical University Hospital, Kaohsiung, Taiwan
[3] Department of Surgery, Korea University College of Medicine, Seoul, Corea Del Sud

Objective: The safe use of Ligasure Small Jaw (LSJ) next to the recurrent laryngeal nerve (RLN) has not been already tested, in detail: 1) which is the safety distance from the RLN and how long can be the LSJ applied? 2) is the RLN dissection safe, immediately after the use of LSJ?
Methods: The research project has been approved by the Animal-Care-Kaohsiung-University (Taiwan). Duroc-Landrace pigs underwent orotracheal intubation with a proper electromyographic (EMG) tube. We used a continuous intraoperative neuromonitoring system (C-IONM) in order to reveal EMG modifications during dissection. We evaluated the safety of LSJ under different conditions according to an experimental model:
1) LSJ use (N=4, power 2): distance from the nerve = 5 and 2 mm; 1st LSJ application = 5 sec, if no EMG change was detected 2nd application = 10 sec, if no EMG change 3rd application = 15 sec. When the C-IONM revealed any EMG alteration we performed a 20 min follow-up to observe an eventual nerve recover.
2) We observed the effects produced by biting the nerve with the LSJ after its employment on other tissues (N=2). We touched the nerve with the LSJ immediately after test applications on a muscle. 1st LSJ application = 5 sec, if no EMG change was detected 2nd application = 10 sec, if no EMG change 3rd application = 15 sec. When the C-IONM revealed any EMG alteration we performed a 20 min follow-up to observe an eventual nerve recover.
Results: Our results show that direct contact on the nerve with the LSJ immediately after its use on other tissues should be avoided. For a safe use of the LSJ we need to keep a 2 mm safety distance from the RLN for less than 5 sec. The C-IONM observed EMG alterations were reduction of amplitude and increased latency.
Conclusions: The C-IONM is a useful tool for the evaluation of RLN functional alterations during thyroid surgery. We propose a standardized use of the LSJ also near the RLN.

PREDICTIVE FACTORS FOR FAILURE OF TOTAL THYROIDECTOMY

A. LEOTTA, S. RAUSEI, F. ROVERA, C.C. FERRARI, M. LAVAZZA, A. MANGANO, D. INVERSINI, F. FRATTINI, S. SPAMPATTI, M. ANNONI, L. BONI, G. DIONIGI

Department of Surgery, University of Insubria, Varese, Italia

Objective: How to determine predictive factors for subtotal thyroidectomy (TST).
Methods: Prospective analysis of 1488 patients admitted for total thyroidectomy (TT) between 2003 to 2013. Main measure of analysis is the failure of total thyroidectomy (FTT), and TST.
Results: Among the 1488 patients who were proposed for a TT, 91 patients (6.1%) underwent TST. Multivariate analysis identified as independent preoperative predictors of FTT: age> 75anni, BMI> 35, thyroiditis. Predictive factors of intraoperative FTT: length of intervention> 100min, no identification of the recurrent laryngeal nerve, non-use of neuromonitoring, use of energy based devices.
Postoperative factors: gland volume> 85ML. The probability of FTT was 8% if there wasn't any predictor, 18% if one was present, and 41% if > 2 was present. The distribution curve FTT is related with time. Overall morbidity of FTT was equal to TT (12.7% vs.13,9%, P> .05). During the study period, 20% of patients (19/91) required completion of thyroidectomy.
Conclusions: 6% of the patients are subjected to less of TT. Pre-, intra-and postoperative predicting factors for FTT have been identified.

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HUGE CYSTIC PARATHYROID CARCINOMA: CASE REPORT AND SYSTEMIC LITERATURE REVIEW

G. DI MEO, A. GURRADO, S. GIUNGATO, F. FRAGASSI, L.I. SGARAMELLA, R.M. ISERNIA, I. VOGLIACCO, G. PICCINNI, M. TESTINI

UO di Chirurgia Endocrina, Digestiva e d'Urgenza; Dipartimento di Scienze Biomediche e Oncologia Umana, Università degli Studi di Bari 'A. Moro', Bari, Italia

Introduction: Parathyroid Carcinoma is a rare but ominous cause of primary hyperparathyroidism (PHPT), showing an incidence of less than 1.0% of PHPT, and a prevalence of 0,005% of all cancers.
Case presentation: We report a case of a 62 year-old man, admitted to our Department of General Surgery with a large asymptomatic, left-sided palpable neck mass, hypercalcemia (11.7 mg/dl), high levels of PTH (391.7 pg/ml), and polyuria. US-color-doppler showed a multinodular thyroid and a partially retrosternal huge cystic mass adjacent to the left lobe of thyroid. CT-scan confirmed the extension into the upper mediastinum of a large lesion (12 cm in diameter). A FNAB was performed and cytology demonstrated a neoplasm of parathyroid. A surgical resection of the thyroid with *en bloc* the parathyroid mass and a central lymphnode dissection were performed. Strong adherence among the mass, pre-thyroid muscles, left recurrent laryngeal nerve and oesophagus was found and a careful dissection was obtained through microsurgical technique. An intraoperative endoscopy showed the oesophageal integrity without macroscopically infiltration. Histology confirmed the diagnosis of parathyroid carcinoma without thyroid involvement and any lymphnodal metastases.
At 15 months follow-up the patient is in good clinical condition and disease-free.
Conclusions: Up to now, the systematic literature has shown only three cases of >5 cm in diameter cystic carcinoma of parathyroid. Parathyroidectomy with ipsilateral thyroid lobectomy and central neck dissection is mandatory when a preoperative diagnosis of parathyroid carcinoma is performed.

ROLE OF SURGERY IN THYROID CANCER TREATMENT

A. DIBRA[1], X. DRAÇINI[1], S. KELLIÇI[2]

[1] First Clinic of General Surgery UHC "Mother Theresa" Tirana, Tirana Medical University, Tirana, Albania
[2] Faculty of Pharmacy, Tirana Medical University, Tirana, Albania

Objective: The lack of approved guidelines for optimal treatment and of a National Cancer Registry in Albania, contributes greatly to the increased mortality by cancer.
Over the past three decades, the incidence of thyroid cancer has increased almost two fold worldwide, without any changes in the mortality rates.
Methods: The aim of this communication is to present the actual recommended guidelines for the surgical treatment of thyroid cancer.
Results: In the treatment of thyroid cancer, several options may be considered such as surgery; radioiodine therapy; external beam radiation and thyroid hormone suppression in a multidisciplinary frame, including surgeons, pathologists, radiologists, endocrinologists ans clinical pharmacists. Surgery is the main stay of the treatment for differentiated thyroid cancer. The surgical modalities can be total thyroidectomy; near – total thyroidectomy and unilateral lobectomy and isthmusectomy. Surgery intention in differentiated thyroid carcinoma is to eradicate all visible tumor foci and local lymph nodes. Actual surgical guidelines recommend that most patients with differentiated thyroid cancer are best treated by total (or at least near – total) thyroidectomy, followed by radioiodine therapy. In the presence of visibly involved lymph nodes, prophylactic lateral neck dissection is mandatory. On the other hand, in undifferentiated thyroid cancer, as anaplastic carcinoma, the surgical treatment is indicated primarily for relief of airway obstruction. Total thyroidectomy and radical neck dissection have no advantage over debulking of the tumor that can be considered the most adequate treatment, completed with other modalities as external beam radiation etc.
Conclusions: Thyroid cancer remain a very serious disease and its optimal treatment and associated survival depends mostly in a multidisciplinary treatment approach, focused on surgery.

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PREOPERATIVE LOCALIZATION OF PARATHYROID ADENOMA IN MININVASIVE ERA

B. DE SIMONE, G. FALLANI, F. CATENA

Dipartimento di Chirurgia d'Urgenza, Ospedale Universitario di Parma, Parma, Italia

Objective: A correct preoperative localization of hyperfunctioning parathyroid gland, reduces the rate of recurrence of primary hyperparatirodism (pHPT). The aim of this study is to verify what is the role of the use of ultrasonography (US) and parathyroid scintigraphy with sestamibi (PSS) in the era of MIVAP.
Methods: We analyzed retrospectively data about all patients underwent MIVAP in our OU of General Surgery and Organ Transplantation (Parma University Hospital) from January 2011 to January 2014 with diagnosis of pHPT; all the data were processed using SPSS statistical system; $p<0.05$ was considered statistically significant.
Results: We identified 61 patients underwent parathyroidectomy for pHPT. 31/61 patients (50.8%) were affected by adenoma (3/31 patients had a double adenoma); 29/61 (47.5%) patients were affected by parathyroid hyperplasia. US revealed the adenoma in 45 patients (73.8%) and was falsely negative in 3 patients (4.9%). 39.3% of patients presented a thyroid disease at US. PSS was performed in 46/61 patients (75.4%); it was positive in 33 patients (54.1%) and falsely negative in 13 patients (21.3%). US and PSS showed concordant results in 42.6% of cases and discordant results in 34.4% of patients.
Fisher's exact test showed a statistical significance in the decrease of the sensitivity of PSS in the identification of the superior adenomas ($p = 0.0004$); US had an highly sensitivity in the localization of the inferior adenomas ($p = 0.0008$). Preoperative serum calcium values, size of the adenoma and preoperative PTH values were not predictive factors in the localization of the hyperfunctioning parathyroid.
Conclusions: PSS showed a reduction in sensitivity in the localization of superior adenomas; US was highly sensitive in the localization of inferior adenomas. MIVAP and intraoperative PTH monitoring allow a correct surgical removal of the hyperfunctioning parathyroid but it's necessary to establish a cut-off value of intraoperative PTH to avoid recurrence of pHPT.

LAPAROSCOPIC COLECTOMY IN URGENT SETTING: SINGLE TEAM EXPERIENCE

A. AGRUSA, G. ROMANO, G. DI BUONO, G. FRAZZETTA, D. CHIANETTA, V. SORCE, L. GULOTTA, S. AMODEO, G. GULOTTA

Department of General Surgery, Urgency and Organ Transplantation, University of Palermo, Palermo, Italia

Objective: Laparoscopic approach has slowly become the standard for treatment of benign and malignant colonic disease. Many systematic reviews have demonstrated the advantages of laparoscopic over open colectomy for elective surgery. The aim of this study is to evaluate the feasibility and safety of laparoscopic colonic resection in urgent setting.
Methods: We performed a retrospective analysis in the period between January 2010 and December 2013 at General Surgery and Emergency Department of the University Hospital Policlinico "P. Giaccone" in Palermo. We selected 32 patients with colonic malignancy and clinical presentation of bowel obstruction (24 cases, 22 on left side and 2 on right side), colonic perforation (7 cases on the left side) and recurrent gastrointestinal hemorrhage (only a patient). Exclusion criteria for laparoscopic approach were presence of local infiltration and peritoneal carcinosis. The presence of peritonitis is not considered controindication to laparoscopic surgery.
Results: The median age was 61.5 years (range 42-78), BMI was 27.5 kg/m^2. Mean pre-operative time was 10.5 hours (range 3 – 26 h). There was no significative intra-operative bleeding. 8 patients had a history of previous abdominal surgery. Conversion to open surgery was required in one case for massive bowel dilation. There was no mortality within 30 days period.
Conclusions: This study shows that laparoscopy is a feasibility procedure in urgent setting for a variety of clinical presentations. In selected patients laparoscopy give good outcome with minimal complications. Other comparative studies are needed for validation and extension of technique.

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OUR EXPERIENCE IN EMERGENCY COLON CANCER TREATMENT

A. DIBRA, X. DRAÇINI, D. SHEHI, D. GODAJ, E. CELIKU

First Clinic of General Surgery UHC "Mother Theresa" Tirana, Tirana Medical University, Tirana, Albania

Objective: Emergency surgery for colon cancer is widely thought to be associated with increased likelihood of surgical morbidity and mortality; however, other coexistent factors such as advanced disease, the age of the patient, and medical comorbid conditions may also influence these outcomes.
Methods: All patients treated surgically with adenocarcinoma of the colon between june 2009 and june 2014 were registered retrospectively. Postoperative mortality and complication rates in elective and emergency patients were compared. Logistic analysis was used to identify independent risk factors for postoperative complications.
Results: Emergency indications for surgery were defined as peritonitis, intra-abdominal abscess, or complete bowel obstruction at presentation (defined as emesis, distention on examination, and confirmatory plain radiograph films).
Conclusions: Emergency surgery has a strong negative influence (beyond that which is expected based on stage of disease) on immediate surgical morbidity and mortality. It was associated with high rates of complications, indicating that immediate surgery should be avoided if possible.

HOMODIGITAL DORSAL ADIPOFASCIAL PERFORATOR FLAP: RECONSTRUCTION OF APICAL LESIONS

E. CIGNA[1], G. DELIA[2], L. LOSCO[1], A. CONVERSI[1], A.M. SPAGNOLI[1], D. RIBUFFO[1], F. STAGNO D'ALCONTRES[2], N. SCUDERI[1]

[1] UOC Chirurgia Plastica, "Sapienza" Università di Roma, Roma, Italia
[2] Dipartimento di Specialità Chirurgiche - Chirurgia Plastica, Università degli studi di Messina, Messina, Italia

Objective: Dorsal digital lesions reconstruction can be a challenge for the surgeon. Nail bed injuries and bone exposure can complicate hand reconstruction.
A reconstructive plan, if possible, should be pursued also in acute lesions associated with moderate functional loss (digital lenght impairment, nail loss).
A functional loss of low impact on the quality of life in patients with distal digital amputations, could influence the relational life of the patient and have a significant psychological impact. We report our experience with homodigital dorsal adipofascial perforator flap for repair of dorsal digital losses.
Methods: From June 2011 to May 2014, 25 patients were treated in emergency. In 20 patients was performed reconstruction with homodigital dorsal adipofascial flap vascularized by both perforating arteries, 5 patients were treated with homodigital dorsal adipofascial flap vascularized by one of the two digital perforators.
Results: In all patients was observed a complete survival of the flap without postoperative complications such as partial or total necrosis of the flap. At postoperative examination, in all cases in which the matrix was not damaged by the trauma, it was observed a slow regrowth of the nail. All patients recovered tactile sensitivity.
Conclusions: The reconstruction following trauma of the distal side of fingers resulted safe and effective with both methods, providing a good vascularization and cover of exposed bone. The technique which uses one digital perforator artery for the vascularization of the dorsal adipofascial flap showed equal validity compared to most common technique that exploits both perforators. The aesthetic result takes advantage of a single vascular pedicle leading therefore to a lower bulking effect in dorsal region near eponychium.