

Conference Abstracts

Selected Abstracts

IXth Romanian-Serbian Conference of Surgery

SIBIU, NOVEMBER 27-28, 2014



RISK FACTORS OF ANASTOMOTIC FISTULAS AFTER LOW RECTAL CANCER SURGERY

Denis Aslan, F. Grama, D. Cristian, T. Burcoş

Coltea Hospital, Bucharest

Keywords: low rectal cancer, sphincter-sparing, anastomotic fistula

Introduction: The surgical treatment of rectal cancer is constantly improving in order to preserve the anal sphincter. However, the risk of postoperative complications is still present. Among these, anastomotic leakage increases morbidity, hospitalization time and costs, prolongs the recovering time and increases the risk of a second surgery.

Methods: We studied a group of 26 patients affected with middle and lower rectal cancer with sphincter-sparing surgery on the Surgical Department of Coltea Hospital in Bucharest (23 patients with colo-rectal anastomosis T-T with mechanical staplers and 3 patients with colo-

anal anastomosis). We analyzed the surgical technique, neoadjuvant treatment, the patient's condition and postoperative complications.

Results: Patients were enrolled into 3 groups: 6 (23.07%) patients with colo-rectal anastomosis without any other protection of the anastomosis, 18 (69.23%) patients with protective ileostomy and 2 (7.69%) patients with multiperforated transanal transanastomotic tube. 2 (7.69%) patients were operated laparoscopically. We have identified 2 (7.69%) anastomotic fistula with low flow closed under conservative treatment.

Conclusions: The risk of anastomotic fistula after sphincter-sparing surgery in case of low rectal cancer is still elevated and it depends on many factors related to both patient status and the surgical technique. The lower localisation of the rectal cancer increases the risk of anastomotic fistula.

"This work received financial support through the project entitled "CERO – Career profile: Romanian Researcher", grant number POSDRU/159/1.5/S/135760, cofinanced by the

European Social Fund for Sectoral Operational Programme Human Resources Development 2007-2013”.

DOES ERAS IN PANCREATIC RESECTIONS APPLY IN EASTERN COUNTRIES?

T.S. Barbu

4th Surgery Department, University of Medicine and Pharmacy “Iuliu Hatieganu”, Cluj-Napoca, Romania

Enhanced recovery after surgery (ERAS) is a perioperative and postoperative care concept aiming to reduce the length of hospital stays following elective abdominal surgery. Twenty treatment items defined in the Consensus Guidelines established in 2012 were included in this concept. The success of ERAS depends highly on multidisciplinary teamwork and patient compliance. For pancreatic surgery, guidelines were implemented by several institutions, and we have today 2 systematic reviews reporting good results.

The implementation of ERAS into clinical practice is hampered by the poor compliance with ERAS protocols and remains a challenge for the future. Analyzing the steps for implementation, the highest difficulty is to defeat the dogmas of traditional perioperative care. Furthermore, a dedicated multidisciplinary team is needed to prepare the patient on an out-patient basis, to perform surgery the day of admission, and to strictly follow all postoperative measures of care. This team needs a constant back-up, and help to complete forms, consents, and lot of papers to follow compliance with protocols.

Implementation of the program in Eastern European countries will be possible only by introduction of National Programs, which will provide the constant back-up needed. This can be done only if the health system understands that ERAS follow its aims of reducing length of stay and costs in pancreatic surgery.

RECTAL PROLAPSE - ALGORITHM FOR TREATMENT

G. Barisic, V. Markovic, Z. Krivokapić

Clinic for digestive surgery, First Surgical clinic, Clinical Centre of Serbia Belgrade School of Medicine

Rectal prolapse is defined as the protrusion of the full thickness of the rectal wall through the anus. The etiology of rectal prolapse is unclear. Factors involved in the development of rectal prolapse may be congenital or acquired. There are conditions that can be associated or which predispose to the development of rectal prolapse. These include various intestinal disorders such as constipation and chronic straining, neurologic diseases such as spinal cord abnormalities, lack of rectal fixation to the sacrum, previous anorectal surgery, and pelvic floor defects. Fundamentals for the development of rectal prolapse are presence of an abnormally deep pouch of Douglas, lax and atonic muscles of the pelvic floor and anal canal, weakness of internal and external sphincters, pudendal nerve neuropathy, lack of normal fixation of the rectum, with a mobile mesorectum and lax lateral ligaments.

The peak incidence of rectal prolapse is in the fourth and seventh decades of life. Clinical exam often reveals prolapsed rectum in the sitting position or during straining. Digital exam shows weakened anal sphincters in most cases. However, thorough investigation is suggested in order to reveal associated abnormalities and to choose adequate operative treatment. Anal manometry, defecography/ preferred NMR defecography/, colonoscopy, barium enema, endorectal ultrasound and colonic transit studies are usually warranted because 50 to 75% of the patients with rectal prolapse have coexisting fecal incontinence and constipation is associated with prolapse in 15% to 65% of patients.

More than 100 procedures have been described for the management of rectal prolapse in the last century. The purpose of rectal prolapse surgery is to correct the prolapse and if possible to restore fecal continence. This can be achieved by resection or plication of the redundant bowel and fixation of the rectum to the sacrum. All surgical procedures can be divided into two groups; transabdominal and transperineal. Among transperineal, most popular are Delorme's procedure and Altemeier's procedure. Delorme's procedure is still very popular, especially in older and fragile patients because operative risk is low. Mortality rates after this procedure are in range 0% to 4% while recurrence rates vary between 4% and 38%. Altemeier operation is an attractive procedure due to minimal hospitalization and disruption in the patient's life and reduced potential risk of injury to the pelvic nerves.

However, mortality rates are 0-5% and recurrence rate is in the range of 0 to 16%.

Abdominal procedures differ according to the surgical technique (mobilization-only, mobilization + rectopexy, mobilization + sigmoid resection + rectopexy), surgical access (laparoscopic or open) and method of rectopexy which can be performed by suture or by using mesh. Suture rectopexy has low mortality but recurrence rates are in range 0-27%, in most series 0-3%. Laparoscopic rectopexy has mortality rates 0% to 3% and recurrence rates 0% to 10%. Posterior mesh rectopexy has mortality rates 0% to 1% and recurrence rates 0% to 6% /for both absorbable and nonabsorbable meshes/.

Anterior sling rectopexy /Ripstein procedure/ has mortality rates 0% to 2.8% and recurrence rates 0% to 13%. Addition of sigmoid resection to rectopexy has mortality rates 0% to 6.7% and recurrence rate 0% to 5%.

In summary, abdominal operations have lower recurrence rates and potential functional improvements. Abdominal procedures are ideal for young, fit patients while perineal procedures should be reserved for older, frail patients with significant comorbidity.

CLOSTRIDIUM DIFFICILE INFECTION FOR PATIENTS UNDERWENT MINIMALLY INVASIVE PROCEDURES

M. Beuran, B. Gaşpar, I. Tănase, B. Stoica, R. Gănescu, I. Negoii, B. Popescu, S. Păun

Keywords: Clostridium difficile, surgery, medical treatment

Introduction: Toxigenic *Clostridium difficile* is responsible for a broad spectrum of disease ranging from diarrhoea to fulminant colitis. This severe form occurs only in 3-5% of the affected patients, most of the cases being treated within 10 days. The literature reports *C. difficile* infection with surgeries (31%), gastrointestinal surgeries (15%), endoscopy (24%), and barium enema (5,5%)

Method: We present the patients that underwent minimally invasive procedures and developed *Clostridium difficile* infection while admitted in Bucharest Emergency Clinical Hospital for the last 11 months.

Results: For the studied period of time, a number of 35 cases with *Clostridium difficile* infections were encountered. The diagnosis'

suspicion raised after the patients had diarrhoea (three or more loose bowel motions in one day). The positive diagnosis was established by *C. difficile* positive stool cytotoxin test (*C. difficile* toxin A/B). In our study, 23 patients underwent surgery (17 open surgery and 6 minimally invasive surgery). From these patients only 9 underwent gastrointestinal surgeries. 5 patients had either endoscopy/colonoscopy or ERCP performed prior the positive diagnostic. The remnant 7 patients had no invasive diagnostic or therapeutic procedures performed were either clustering cases or following prolonged antibiotherapy. The majority of the patients were treated either by vancomycin or metronidazole or conservatively, no patients required colectomy for fulminant colitis.

Conclusions: Proper diagnosis and immediate therapeutic measures are compulsory for patients with *Clostridium difficile*, especially those immune suppressed patients (elderly, patients that underwent surgical treatment, or patients with multiple comorbidities).

MULTIMODAL THERAPY OF RECTAL CANCER

M. Breberina, T. Petrović, Z. Radovanović, V. Selaković, M. Ranisavljević, D. Lukić

Dept. of Surgical Oncology, Institute of Oncology of Vojvodina, Sremska Kamenica Faculty of Medicine, University of Novi Sad, Serbia

Decision, whether neoadjuvant therapy shall be used or not is brought according to the preoperative pathohistological diagnosis and staging methods for the tumor, of which Magnetic resonance imaging (MRI) is the best and standard method. If MRI shows that mesorectal fascia is involved by the tumor, or the tumor is very close to this fascia, < 1 mm, (T3), or the tumor involves adjacent organs (T4), it is recommended long course of CRT (50 Gy in 25 fractions) with concomitant chemotherapy.

There does not exist consensus on when to perform operation after finishing preoperative CRT. Most commonly it is waited 6 – 8 weeks from the last day of CRT, but on our department we have an experience that it is better to wait for a little longer time, 10 – 12 weeks.

In the case when the tumors are not as big as above described (small T3 or big T2) it is recommended short course of RT (so called Swedish protocol) 25Gy (5 fractions of 5 Gy).

The patient is operated immediately after finishing of irradiation, or the latest on the 9th day counting from the first day of RT.

By the use of the neoadjuvant CRT, we got bigger incidence of radical operations in locally advanced tumors (90% and more), lower incidence of local recurrency (from 30 – 40% to 10 – 15%). Only overall survival, alas, is not better as it was expected.

IS OPEN REPAIR STILL THE GOLD STANDARD IN THE TREATMENT OF RAAA?

I.S. Cinara, Andrija Dimic, Lazar Davidovic

Clinic for vascular and endovascular diseases, Clinical Centre of Serbia, Belgrade

Keywords: AAA, EVAR, cell saver, Endovascular, open surgery

The lecture is based on literature analysis but also, on my Clinic's significant experience with the treatment of ruptured aneurysms. One of the conclusions of this meta-analysis which includes our experience as well, is that the mortality after OR of ruptured aneurysms, was not changed over the past 15 years. So, Is EVAR a better solution for patients with RAAA? These selected studies, meta-analyses and reviews have mostly shown that REVAR is associated with significantly lower 30 day mortality in comparison to open surgery. Finally results of two the first randomized prospective multicenter studies followed. According to AJAX trial 30-day mortality after open and endovascular repair of ruptured aneurysms, was similar. In their initial report authors of IMPROVE trial said. Even though it is not recommendable to confront the leading vascular surgeons from the Eng, allow me to remain you that our single center experience includes more than 1000 RAAA. IMPROVE trial, also did not show significant difference regarding 30-day mortality, duration of procedure and 30 day cost, between endovascular and open repair groups. EVAR in cases under local anesthesia have been associated with a lower mortality than those under general anesthesia. 30-day mortality after EVAR at relative hemodynamic stable patients with good aortic anatomy, has been 25%. But this group represents only 60% of pts with RAAA. Besides well known advantages REVAR, has also, some limitations. Those are profound hypovolemic shock and unfavorable

and aneurysmal anatomy. An additional problem might be mid and long term results. Developing countries such as Serbia, should think also, about financial issues. In this article by Lachat group the cumulative risk of secondary intervention after REVAR was 35% at 2 years and more than 40% at 3 years. Than there is no significant difference regarding long term surviving and quality of life between open and endovascular repair of RAAA. Now I will have to say something what does not make me quite happy. The difference between the possibility of vascular medicine in developed and undeveloped countries is increasing significantly. Serbia and other undeveloped countries can not to apply endovascular procedures at a sufficient level and to a sufficient extent. I am sure that you do not possibly expect from us to give up on our patients with RAAA, due to the lack of stent grafts. All being said, that open RAAA repair is still very important. But, can we improve early surviving? Yes we can according to this our analysis. In the period between 1991 and 2004 the 30-day-mortality after RAAA OR in our Clinic was 48.3%, while in the period between 2004 and 2012 it was 37.4%. The difference was obvious. What has been shown by the analysis of the mortality?

Considering factors that have been associated with increased 30 days mortality, our two studies were not so different. How did we manage to improve early surviving during the second period of our investigations? I believe that is the employment of modified Crawford's strategy. At pts with onset abdominal or low back pain who have pulsatile abdominal tumor and profound shock, we perform emergency surgery after ultrasonography confirmation. If the TA is over 100 mmHg, after ultrasonography confirmation, patient is admitted to ICU. Emergency surgery is performed after additional analysis. MSCT is performed only at perfectly stable pts, or pts with suspected suprarenal or ThAAA. Thanks to previous strategy we significantly reduced the mean time to arrival in an operating suite. Namely in the previous period this time has been 128 min. In comparison to AJAX and IMPROVE TRIALS 35 minutes is very good time concerning the fact that we establish the dg of RAAA outside of our clinic. One of the biggest mistakes in the initial RAAA treatment, is an aggressive restitution of circulatory volume. It increases TA that, in addition, annuls the initial retroperitoneum tamponed and leads to new bleeding with

conversion of retroperitoneal rupture into intraperitoneal one. Crawford was the first to insist on "permissive hypotension". Volume should be compensated to a level required to maintain consciousness and to prevent ST depression. We routinely perform RAAA OR under supraceliac ACC. That is a fast, efficient and safe proximal bleeding control, which in addition enables to prevent iatrogenic injuries in the presence of retroperitoneal hemathoma. In contrast to our previous, during our second study, ICS was used routinely. This procedure is significant during RAAA OR for three reasons. First of all, it enables immediate beginning of the operation. Before we determined blood type and supply a blood. Then, the consequences of allogeneic blood deficit is annulled (a-nnol) with intra operative cell saving and autotransfusion. Quite often exsanguinous transfusion is necessary during OR of RAAA. When pt receives a large amount of allogeneic blood, ARDS occurs more often. According to this our study, the intraoperative cell saving with autotransfusion, has evident clinical and financial effects during RAAA OR. Because of that the education of young vascular surgeons in open aortic surgery is extremely important.

Instead conclusion I have 3 messages to our young colleagues. Currently, all RAAs are not suitable for EVAR.

LAPAROSCOPIC ALTERNATIVE IN TREATMENT OF SMALL EVENTRATIONS AND UMBILICAL HERNIAS USING PROSTHETIC MESH WITH OMENTUM OVERLAY

D. Bratu, A. Mihetiu, Al. Sabău, Anca Dumitra, L. Beli, D. Sabău

IInd Surgery Clinic, Clinical County Emergency Hospital Sibiu, Romania

Keywords: umbilical hernia, postincisional hernia, minimally invasive, laparoscopic approach, overlaid omentum mesh.

Introduction: Umbilical hernias and abdominal incisional hernias represent pathologies which required numerous surgical ways of treatment in prosthetic or nonprosthetic, open or laparoscopic surgery. The method proposed by us is a less expensive option with no additional risks compared to other similar procedures as surgical technique.

Materials and methods: We conducted a retrospective study during 01.01.2009-01-

01.08.2014 in which we considered a number of 36 patients with umbilical hernia and eventration, patients who benefit by a laparoscopic intraperitoneal polyester mesh covered with omentum, procedure applied at IInd Surgery Clinic, Clinical County Emergency Hospital Sibiu.

Results: From 36 patients with postoperative umbilical hernia and eventration cases in which we used this surgical technique, 21 were umbilical hernias and 15 post incisional hernias. The average time of surgery was 1 hour and 25 minutes, recording 5 postoperative complications remitted under conservative treatment, with a mean hospitalization of 3,1 days.

Conclusions: Proepiploic laparoscopic treatment using omentum is a reliable alternative to a more expensive and difficult procedure involving Dual Mesh.

TRANSTHORACIC NEEDLE BIOPSY (TNB) UNDER DIFFERENT GUIDING METHODS THE EXPERIENCE OF THE THORACIC SURGERY CLINIC OF CRAIOVA AFTER FIRST 175 CASES

A. Demetrian¹, A. Dobrinescu¹, I. Mîndrilă¹, Dana Albulescu², Serenada Bălă³, S. Râmboiu⁴, E. Georgescu⁴, Camelia Demetrian⁵, S. Nicolae⁶, A. Dicianu⁶, S. Dumitrescu⁶, I. Georgescu⁴

¹Thoracic Surgery Clinic, University of Medicine and Pharmacy of Craiova,

²Radiology Laboratory, Emergency Clinical Departmental Hospital of Craiova,

³Pathology Laboratory, Emergency Clinical Departmental Hospital of Craiova,

⁴Surgery I Clinic, University of Medicine and Pharmacy of Craiova,

⁵Pneumology Clinic, University of Medicine and Pharmacy of Craiova,

⁶Medical Student, University of Medicine and Pharmacy of Craiova

Introduction: Transthoracic needle biopsy (TNB) is a minimal invasive method very useful to establish the histopathological diagnosis of intrathoracic tumors, avoiding when is technically possible more complex diagnostic interventions (mediastinoscopy, thoracoscopy, exploratory thoracotomy). It can be performed under CT, ultrasound, fluoroscopy or without guidance.

Materials and methods: We present our experience in this field, analyzing the first 175 transthoracic needle biopsies performed in the Thoracic Surgery Clinic of Craiova in a period of 3 years and 10 months.

Results: Various guiding methods were used to localize the tumors in 49% of cases (fluoroscopy, ultrasound, computed tomography) but most interventions (51%) were performed without guidance, oriented only by chest CT examinations already carried out, and then using anatomical landmarks.

Obtaining a tissue fragment required for histopathology examination was possible in 100% of cases with a histological confirmation rate of 82%. 7 complications were encountered (important pneumothorax requiring pleural drainage in 4 cases, accidental puncture of the liver in 2 cases and severe hemoptysis in one case).

Conclusions: Transthoracic needle biopsy (TNB) is a method of rapid diagnosis, minimally invasive, cheap and safe, contributing to histopathological confirmation of intrathoracic tumors and without delay initiation of treatment.

THE REMARKABLE EFFECTS OF VACUUM THERAPY IN EVISCERATION – CASE PRESENTATION

Anca Dumitra, Al. Sabău, O. Tobias, D. Sabău

„Lucian Blaga” University Sibiu, Center of Surgical Research

Introduction: The therapy of evisceration is a challenge for surgeon and in several cases is very difficult.

Material and Method: Patient age 53 with esophageal cancer st. VI with invasion in mediastinal structures was operated through laparogastroscopic approach and stented in 2011. After 2 years the esophageal stent migrated in stomach and we reinserted the stent at this time in open surgery, but the general status of the patient was severe altered and he suffered an evisceration. The surgical repair of evisceration was followed by another evisceration in the context of severe imbalance of metabolic status, difficult to correct.

Results: After the insertion of the vacuum system Vivano Hartmann the general status was improved and the abdominal wound had a

very good evolution, in one month we had the possibility to enclose it.

Conclusions: In the absence of vacuum therapy the patient had no chance to cure due to the severe metabolic imbalance and the lack of efficiency of usual surgical methods.

SINGLE VISIT ENDOVENOUS LASER TREATMENT AND TRIBUTARY PRECEDURES FOR SYMPTOMATIC GREAT SAPHENOUS VARICOUS VEINS

C. Duță, Dana Barjica, Eniko Hordovan, S. Abdulah, V. Nicolaescu, P. Medeleian

Introduction: Endovascular Laser Treatment for varicose veins had decreased morbidity and recovery time compared with open surgery. This study presents the outcomes and midterm results of endovenous laser treatment alone or combined with phlebectomy and crosectomy.

Material and Methods: It is a retrospective study of 2,000 procedures. The study included 1,650 patients treated between 2008 and 2012.

Results: The absence of reflux 100% of cases at the first year follow up and 98.2% in the third year follow up. Crosectomy is associated in the case of internal saphenous vein more than 13 mm. We used the diode laser wavelength of 918 nm and 1470 nm and local and general anesthesia. Most represented cases belong to CEAP class III - 68%, followed in order of CEAP II - 13% and IV - 11%. Intraoperative complications - bleeding 3%, postoperative complications: deep thrombophlebitis - 3 cases, premaleolare intense pain - 12 cases, persistent edema - 129 cases.

Conclusions: The endovascular laser treatment of varicose veins is a safe and effective method. But the procedure is limited by costs.

MINIMALLY INVASIVE THERAPEUTIC OPTIONS IN PANCREATIC PSEUDOCYST

E. Georgescu, S. Sandulescu, D. Cartu, M. Bica, F. Cioara, Daniela Marinescu, Milena Georgescu, S. Râmboiu, V. Șurlin

1st Surgery Clinic, University of Medicine and Pharmacy of Craiova

Pancreatic pseudocyst is one of the most frequent complications of acute and chronic

pancreatitis, patients with these disorders often benefit from interventional treatment or minimally invasive techniques. The real incidence of pancreatic pseudocysts is difficult to assess. It is related to the incidence of the severe acute pancreatitis and the correct follow-up of acute peripancreatic collection.

The proper selection of treatment depends upon knowledge of the therapeutic methods, their limitations and pseudocyst anatomy (size, location, ductal anomalies). Open surgery sees his indications decreasing in the management of pancreatic pseudocysts and minimally invasive techniques represented by CT treatment of pancreatic pseudocyst.

There are no randomized studies to develop a therapeutic protocol of pancreatic pseudocyst, this therapy is individualized for each case depending on the treatment options available.

We studied 32 patients diagnosed with pancreatic pseudocyst who are treated by minimally invasive techniques (CT guided external drainage and endoscopic transmural or transpapillary drainage) and we compare the indications, limits, efficiency and complications of these methods.

LANDMARKS FOR NERVE GUIDED TOTAL MESORECTAL EXCISION (TME)

F. Grama, D. Cristian, Denis Aslan, G. Richițeanu, T. Burcoș

General Surgery Department, Colțea Clinical Hospital, Bucharest, Romania Carol Davila University of Medicine and Pharmacy, Bucharest, Romania

Keywords: autonomic nerves, genitourinary disorders, total mesorectal excision, rectal cancer surgery

Introduction: According to published studies, the rate of genitourinary disorders (GUD) related to surgical nerves damage during TME is still at a high value. **Material and Method:** In the last 4 years, 107 consecutive patients with oncological rectal resections (68 open, 39 laparoscopic) were prospectively pre-and post-operative evaluated. These evaluations were done according to the international genitourinary function scores (IPSS, IIEF, FSFI) in order to identify the patients with postoperative GUD (28 patients = 26.2%). For these cases we reviewed the surgical videos, surgical registry and had discussions with surgeons with the purpose of

establishing the potential lesion site for the autonomic nerves in TME.

Results: Based on our experience and on the revised literature we present the critical areas for nerves damage and useful anatomical landmarks for a proper nerve guided surgery.

Conclusions: Although the nerve sparing TME technique has been already well-defined, the autonomic nerves could still be affected in some key risk zones during surgery. In order to reduce the postoperative GUD caused by nerves' injuries it's necessary to improve the quality of surgery with an awareness of the pelvic nerves pathway.

"This work received financial support through the project entitled "CERO – Career profile: Romanian Researcher", grant number POSDRU/159/1.5/S/135760, co-financed by the European Social Fund for Sectoral Operational Programme Human Resources Development 2007-2013"

INTRAOPERATIVE MONITORING OF PTH IN SURGICAL TREATMENT OF RENAL HYPERPARATHYROIDISM

B. Kovačević, I. Krdžić, Milena Scepianovic, Vladica Cuk, Z. Stefanović, M. Kenic, Vladimir Cuk

Surgery Clinic "Nikola Spasic," Zvezdara University Clinical Center, Belgrade, Serbia

Persistent and recurrent hyperparathyroidism are still the most common complications of parathyroidectomy for secondary hyperparathyroidism. Nevertheless, in current surgical practice, there are no clearly defined criteria that could intraoperatively and/or in the early postoperative period predict occurrence of these complications. Intraoperative identification of valid predictive factors for recurrent disease may have important influence on surgical strategy and significantly reduce percent of patient with persistent or recurrent disease.

Forty-three consecutive patients operated for severe form of secondary hyperparathyroidism were included in this prospective study. The values of parathyroid hormone, calcium, phosphate, albumin, alkaline phosphatase and magnesium are determined intraoperatively, during five postoperative days and eight months postoperatively. Our goal was to identify biochemical parameters that could intraoperatively and/or in the early postoperative

period accurately identify patients with persistent or recurrent disease.

Intraoperative decline of the parathyroid hormone for more than 91.6 percent from preoperative values, fifteen minutes after excision of the last gland, showed 100 percent sensitivity and 86 percent specificity in prediction of persistent hyperparathyroidism. We didn't confirm predictive value of any other biochemical parameters that were measured in this study.

Intraoperative monitoring of the parathyroid hormone decline during parathyroidectomy for secondary hyperparathyroidism can reliably identify patients with unsuccessful operation. The application of this technique during parathyroidectomy could have significant impact on surgical strategy and increase percent of successfully treated patients.

LAPAROSCOPIC CHOLECYSTECTOMY FOR PARTICULAR CASES

I. Lică, I. Bassula, D. Suhaciu, M. Lică, G. Jinescu, M. Beuran

General Surgery Department, Clinical Emergency Hospital, Bucharest, Romania

Keywords: situs inversus, laparoscopic cholecystectomy, gangrenous cholecystitis, cholecystoenteric fistula, difficile cholecystectomy

Laparoscopic cholecystectomy can be difficult to manage if we face with complications or abnormalities.

We present a suit of three cases of particular cholecistectomies: cholecysto-duodenal fistula gangrenous cholecystitis and laparoscopic cholecystectomy for a patient with total situs inversus.

Case 1: 73 years old patient (women), who was presented for right upper quadrant pain, accompanied by nausea, vomiting and jaundice onset of symptoms about a week.

Abdominal ultrasound: intrahepatic biliary ducts dilatation - 4mm, principal biliary duct - 11mm; cholecystitis with gallbladder stones about 2.7 / 1,2 cm. Surgery was proceed, videinspection relevated approx 10 mm CBP and colecisto-duodenal fistula - duodenoraphy and cholecystectomy were made. Case 2: 65 years old patient (women), with diabet mellitus type II, presented for moderate right upper quadrant pains and nausea.

Abdominal ultrasound: normal intrahepatic biliary ducts and cholecystitis with gallbladder stones about 1/2 cm.

Laparoscopic approach was made, videinspection relevated gangrenous cholecystitis, whit green friable gallbladder walls, and an intense local inflammatory process, blunt dissection and laparoscopic cholecystectomy was made.

Case 3: 45 years old patient (women) whit total situs inversus presented for biliary colic.

Abdominal ultrasound detected gallstones and emphasizes the situs inversus. Laparoscopic approach was obtain through a mirror American position. Gallbladder was detected on the left side of falciform ligament on visceral hepatic face, retrograde cholecystectomy was performed without incidents and no drain was used.

In particular situations we can use laparoscopic approach to apply with good results.

PANCREATODUODENECTOMY WITH PV, SV AND SMV RESECTION FOR THE PANCREATIC HEAD CANCER - MESENTERIC APPROACH

Z. Milošević

Clinic for Abdominal, Endocrine and Transplantation Surgery, Clinical Center Vojvodina Novi Sad, Serbia

Treatment of the local advanced pancreatic head cancer with vascular (vein) infiltration is still challenging procedure. In contrast to arterial (SMA) infiltration which is the contraindication for the radical resection, vein infiltration (SMV, SV, PV) offers acceptable possibilities for radical surgical operation with complex vein resection and acceptable long term survival results. This video shows mesenteric approach for the huge pancreatic head cancer with local veins infiltrations. Key point is in isolated, (nontouch) pancreatic head resection, with complex veins resection and reconstruction without any kind of grafts.

GASTROESOPHAGEAL REFLUX DISEASE.THERAPEUTICAL OPTIONS

A.C. Munteanu, L. Drăgușin, V. Șurlin, M. Munteanu, L. Vasile, Nicoleta Pogoran, M. Pîrșcoveanu, Anca Ruxanda, Violeta Iordache

U.M.F. Craiova, Romania

Context and Objective: Benign disorders of the esogastric junction, especially gastro-esophageal reflux disease, represents a stimulating scientific competition among many specialties: surgery, gastroenterology, interventional endoscopy. Relationship between gastroesophageal reflux disease and hiatal hernia has not yet been completely understood. It's not fully known if hiatal hernia is a risk, causal or perpetuation factor for gastroesophageal reflux disease. The presence of a hiatus hernia is associated with symptoms of gastroesophageal reflux, increased prevalence and severity of reflux oesophagitis, as well as Barrett's oesophagus. A sliding hiatus hernia disrupts both the anatomy and physiology of the normal antireflux mechanism. The efficacy of treatment with proton pump inhibitors is reduced.

Methods: The material for study consisted of patients diagnosed with GERD, medically treated and followed-up inside the Gastroenterology Clinic of University of Medicine and Pharmacy Craiova; some of them underwent surgical interventions in Surgical Clinics I, II and III. The study was made between July 2006 and August 2012.

Results: The medical management was made with: IPP for 88,24% of patients, of which 79,02% responded positively; anti-H2 was given to 11,76% of patients, 58,33% being considered healed. When the treatment was interrupted, the patients with big hiatal hernia and severe oesophagitis had relapses.

Surgical management. 74,73% of patients were operated through classical surgery and 25,27% through laparoscopic surgery. The classical surgery interventions were mainly total Nissen and Nissen-Rossetti fundoplication (41,18%), followed by partial, anterior or posterior fundoplication type Dor or Toupet (38,24%). In a smaller proportion we used: anatomic proceeding type Lortat-Jacob (10,29%), gastric resection, vagotomy with gastroanastomosis on a Y-shaped loop (6,59%). Seven emergency surgical interventions were made for 4 hemorrhagic complications and 3 obstructive, 2 of volvulus gastric type and 1 intrathoracic strangling of a large hiatal hernia with necrosis, case that led to the single death during the study.

Conclusions: The presence of hiatal hernia in GERD in the present study was a fundamental factor in the finding of reflux esophagitis and Barrett's Esophagus, increasing substantially the risk for the development of such GERD

complications. The presence of hiatal hernia is associated to the symptoms of gastro-esophageal reflux and the larger the size, the more severe the disease. The hiatus hernia is now recognized to be an important aetiological factor at the more severe end of the GERD spectrum.

FOURNIER GANGRENE - A DANGEROUS COMPLICATION IN DIABETES MELLITUS

H. Pîrvanescu¹, Camelia Pănuș², A. Pănuș³, M. Ciurea¹, D. Popa¹, Vladica Roskanovic⁴, Milena Georgescu¹, Diana Clenciu³, V. Pârvănescu¹, C. Gheorghe¹, R. Mercuț¹

¹University of Medicine and Pharmacy Craiova – Plastic Surgery Clinic, Romania

²Emergency County Clinical Hospital of Craiova –Diabetes, Nutrition, Metabolic Diseases Clinic, Romania

³Urodiamed Clinique - Craiova, Romania

⁴Plastic Surgery Department - Carburnesti Hospital, Romania

⁵Clinic of Urology, Emergency County Clinical Hospital of Craiova, Romania

Introduction: A case presentation of a Fournier gangrene in a patient with chronic diabetes complications stage, treated in collaboration with Clinic of Urology and Diabetes, Nutrition, Metabolic Diseases Clinic from the Emergency County Hospital Craiova, Roumania.

Fournier gangrene is a form of necrotizing fasciitis affecting the male genitals organs, a potentially fatal disease characterized by necrotizing of soft tissue infection of the external genitalia, with rapid dissemination along fascial plans with lesions of such as cellulitis, necrotizing and myositis.

Predisposing factors for the occurrence of Fournier gangrene are diabetes, liver cirrhosis, AIDS, alcoholism, malignancies, malnutrition, perineal infection, morbid obesity, paraphimosis, acute arterial cancellations, etc.

Material and methods:

-male, 60 years old

-urban

-T2DM for 5 years, diagnosed after a stroke, in chronic complications stage (neuropathy, retinopathy), treated with oral antidiabetic

-untreated arterial hypertension (BP maximal = 200/110mmHg)

-left hemiplegia post-stroke

Reasons for admission in the hospital: pain, swelling, crepitus and purple skin and gangrene of penile and scrotal regions.

Therapeutic approach: In the Clinic of Urology and Plastic Surgery Clinic the patient undergoes surgery with wide debridement and free skin plasty in penile and scrotal region, and secondary suture in left inghinal region and left lombar region.

Wound care was performed daily (BID) with hydrogen peroxide lavage, chlorhexidine and betadine solution and local dressing.

Postoperative wound with favorable evolution, secondary sutures of the inghinal lombar wounds. Grafts with normal integration.

Diagnosis at discharge:

Ischio-rectal abscess, complicated by necrosis of scrotum and penis Fournier gangrene

Toxic – septic state

Embalanced type 2 diabetes mellitus in chronic complication stage Diabetic peripheral sensori-motor neuropathy

Diabetic preproliferative retinopathy and maculopathy with laser applications (right eye)

Chronic cardiac failure (Class II NYHA) Permanently atrial fibrillation,

Thrid degree arterial hypertension with very high cardiovascular risk Cardiopatie ischemica cronică nedureroasă

Secondary anemia

Major depressive disorder Overweight

Conclusions: Fournier gangrene is a surgical medical emergency, early diagnosis is essential.

-Due to the long period from the onset of injury and presentation to the hospital, especially in a patient with diabetes, as it is in this case, may develop in a possible fatal way.

-The recognition of fatal injuries may require a clinical experience in centers that addressing patients remains high.

LAPAROSCOPIC APPROACH FOR PERFORATED ACUTE APPENDICITIS

St. Patrascu, F.Cioara, D. Cartu, D. Margaritescu, R. Râmboiu, T. Bratiloveanu, Daniela Marinescu, R. Nemes

1st Clinic of Surgery, University of Medicine and Pharmacy of Craiova

Aim: retrospective study of the postoperative results of the laparoscopic approach in perforated acute appendicitis

Material and method: study period 1st of January 2007 – 31st December 2013; 83cases, of

which 30 female patients; average age - 36,27 years (range 16-73 y.), interval onset – hospital admission: less than 24 hours – 11 cases (13.25%); 24-48 hours - 52 cases (62,65%); over 48 hours - 20 cases (24.09%); interval admission - operation: less than 24 hours - 74 cases (89,1%); over 24 hours - 9 cases (10.82%). Symptoms/ clinical signs: guarding/defense - absent – 5 cases; localized – 59 cases; generalized – 7 cases; average value of Ht - 40% (interval 33-46%), average value of leucocytosis: 11.337/mmc (interval 4000-22,500), average value of glycaemia: 106.5mg/dl (interval 57-217mg/dl), average value of blood urea: 29.2mg/dl (interval 12-45mg/dl).

Results: Conversions in open surgery: 14 cases (16.86%). Intraoperative incidents: serosal lesions of cecum -1 case; ovarian tumor of large dimensions needing minilaparotomy for extraction – 1 case, perforation of the base of appendix – 1 case, section of appendiceal base when tying it with extracorporeal knot - 3 cases. Associated interventions: cecorraphy - 3 cases; cure of umbilical hernia -1 case; evacuation of ovarian cyst - 1 case; oophorectomy - 1 case. Postoperative complications: surgical site infections – 3 cases; intraabdominal abscesses 3 cases (3.61%): sub-phrenic abscess (1 case) and left lower quadrant abscess (1 case). Average length of hospital stay: 5.38 days, (interval 2-9 days).

Conclusions: laparoscopic approach in perforated acute appendicitis is feasible and safe.

SENTINEL LYMPH NODE STUDY IN COLORECTAL CANCER

Maria Cristina Sfeclan, I.D. Vilcea, C.S. Mirea, M.C. Ciorbagiu, I. Vasile

IInd Surgical Clinic, Emergency County Hospital, Craiova University of Medicine and Pharmacy of Craiova

Keywords: sentinel lymph node, colon and rectal cancer

In colorectal cancer, the most important predictor for survival is represented by the status of lymph nodes. A minimum of 12 lymph nodes is recommended in order to accurately assess the pN stage. This study's objective was to assess the value (detection rate, accuracy, sensitivity, false negative rate) of the sentinel lymph node pathological evaluation by serial sectioning and usual haematoxylin-eosin staining method. There

were included 43 consecutive operated cases, in which the identification of sentinel lymph node was performed during surgery (in vivo procedure – colon cancer) or immediately after the removal of the resection specimen (ex vivo procedure – rectal cancer). These patients were compared with a control group formed by 45 cases. The detection rate, accuracy, sensitivity and false negative rate were better for colon cancer vs. rectal cancer. For improving the staging of the pN status in colon and rectal cancer there are necessary new studies.

MODIFIED RIVES TECHNIQUE PERFORMED THROUGH DIRECT INGUINAL APPROACH – LAST SOLUTION FOR MOST COMPLEX GROIN HERNIAS

M. Žuvela, D. Galun, I. Palibrk, N. Bidžić, M. Bogdanović, M. Milićević

First Surgical Clinic, Clinical Centre of Serbia, Medical School of Belgrade, Belgrade

Introduction: Challenge for any surgeon is solving complex groin hernias such as groin hernias with hernia defect > 5 cm and increased abdominal pressure, giant inguinoscrotal hernias with loss of domain, and re-recurrent groin hernias with destroyed inguinal canal anatomy.

Aim: The study aim is to present results of modified Rives technique for solving these most complex groin hernias

Material and methods. Between June 2003 - June 2014 116 patients with complex groin hernias were operated on by modified Rives technique performed through direct inguinal approach (in 105 patients unilateral Rives technique, in 9 patients bilateral Rives technique and in 2 patients Rives technique with components separation technique was performed). Forty-five (36%) patients had re-recurrent groin hernia and all operation was performed under regional or general anesthesia as inpatient procedure. The modification of Rives technique consists of the following: the use of a large polypropylene mesh without previous modelling (15x10 cm to 30x20 cm), no lateral notching of the mesh, and anchoring mesh all in a circle around hernia defect.

Results: The mean hernia defect size was 6,8 cm (5-17). The mean operative time was 125 minutes (70-350). The mean postoperative duration in hospital was 4,1 days (1-42). There were two postoperative deaths 14 and 42 days after the surgery due to comorbidities. During a mean follow-up of 47 months (11-132) 1,6 % mesh infection, 4,6% seroma or haematoma, 2,4% chronic pain 5,6% ischaemic orchitis and 1,6% hernia recurrence occurred.

Conclusion: The modified Rives technique performed through direct inguinal approach is good solution for solving most complex groin hernias. Procedure is followed with prolonged operative time, postoperative hospitalisation and need skilled hernia surgeon.