Video

Laparoscopic abdominoperineal resection and left hemicolectomy for synchronous left colonic adult intussusception and low rectal adenocarcinoma

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The technique used to perform a laparoscopic abdominoperineal resection and left hemicolectomy for synchronous left colonic adult intussusception and low rectal adenocarcinoma is demonstrated.

A case of combined laparoscopic cholecystectomy and splenectomy in Jamaica

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Objective: Despite the well-established benefits of minimally invasive surgery, challenges persist in its widespread use in developing countries. We present a video demonstrating the technical aspects and challenges of performing a combined laparoscopic cholecystectomy and splenectomy in a resource-constrained setting.
Subject and Methods: A 34-year old woman with hereditary spherocytosis presented with a four-year history of right upper abdominal pain. Abdominal sonography revealed a moderately enlarged spleen measuring 18 cm and cholelithiasis. Following a normal magnetic resonance cholangiogram, the patient was offered a combined laparoscopic cholecystectomy and splenectomy. The patient was placed in a 30 degree right lateral decubitus position. A total of five trocars – 10 mm optical at umbilicus, 10 mm epigastric, 12 mm left anterior axillary line and two 5 mm – were utilized. Cholecystectomy was performed in the standard fashion and the gall bladder removed through the umbilical port. A Harmonic Scalpel™ device was used to free the spleen from its ligaments. The splenic artery and vein were individually ligated and divided between clips. A sterilized urine collection bag was used to collect the spleen which was morcellated.
Results: Operating time was five hours with an estimated blood loss of 700 mls. The patient was transfused one unit of blood postoperatively. She was discharged on postoperative day three following an uneventful hospital stay.
Conclusion: This case demonstrates that advanced laparoscopic procedures can be performed with good peri-operative outcome in a resource-constrained setting. Careful selection of cases, preoperative planning and requisite expertise are essential in optimizing outcomes.

Laparoscopic subtotal colectomy with ileorectal anastomosis in a 12-year old child

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Objective: There is little data on the feasibility of laparoscopic subtotal colectomy with ileorectal anastomosis (IRA) in children. Through a case report, the technique and the feasibility of the laparoscopic subtotal colectomy with IRA in children is discussed.
Methods: This is a case study of a 12-year old girl with poliposis coli with severe dysplasia in which a laparoscopic subtotal colectomy with IRA was performed. Intra-operative and postoperative data were collected prospectively.
Results: The operation was performed through four ports (5 mm, 5 mm, 11 mm and 12 mm) and a mini incisional suprapubic retrieval site of 2.5 cm. Operative time was 196 minutes, blood loss was minimal, there were no intraoperative or postoperative complications and length of hospital stay was three days.
Conclusions: Poliposis coli warrants a resection of the colon either through a subtotal colectomy with IRA or ileo-pouch-anal anastomosis (IPAA). In selected patients, the procedure needs to be performed at a young age when the subtotal colectomy with IRA is advocated over the IPAA. There is little data to indicate if this can be done safely through laparoscopy in children. In our case, the procedure was done safely at the young age of 12 years with good surgical outcome. It supports the thesis that laparoscopic

subtotal colectomy with IRA can be performed safely in children.

Single incision laparoscopic modified sleeve gastrectomy for submucousal gastric tumour

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Objective: To demonstrate that single incision laparoscopic gastric resections can be done safely and effectively for varying gastric pathologies.
Design and Methods: Patient data were collected and analysed from the single incision laparoscopic gastric resections over the period January 2012 to February 1, 2013. We present a case series of single incision laparoscopic gastric surgery with varying indications: sleeve gastrectomy for metabolic syndrome and modified sleeve gastrectomy for submucousal gastric tumours.
Results: Single incision laparoscopic surgery continues to evolve over recent years. More procedures are being done successfully with a single incision technique. A number of procedures can be performed on the stomach, ranging from repair of perforated ulcer to gastric resections for tumour.
Conclusion: Single incision laparoscopic gastric surgery can be performed safely and with acceptable outcome for a wide range of gastric pathologies.

Laparoscopic resection of a retroperitoneal myolipoma presenting in a right inguinal hernia

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Objective: To report on the feasibility of laparoscopic resection of retroperitoneal lipomatous lesions in the inguinal region, using a trans-abdominal pre-peritoneal (TAPP) approach.
Methods: We present the case of a 79-year old man who presented with bilateral reducible inguinal hernias (right > left). After reducing the right inguinal hernia (RIH), the sensation of a palpable mass was noted in the right iliac fossa. Computed tomography (CT) scan suggested the content of the RIH to be small bowel mesentery and no other mass was noted in the right iliac fossa (missed on CT scan).
Results: A very large 1.8 kg retroperitoneal lipomatous lesion, measuring 22 cm x 16 cm x 8 cm, attached to the right spermatic cord was found and excised laparoscopically during a TAPP approach to repair the hernias. The lesion was pathologically defined as a myolipoma.
Conclusion: The laparoscopic TAPP approach to repair inguinal hernias allows the surgeon to inspect the peritoneal cavity, and in this case it was possible to safely dissect and remove a large, lipomatous, retroperitoneal lesion laparoscopically. To the best of our knowledge, there are no reports of local recurrence, metastatic disease, or malignant transformation of myolipomas and the laparoscopic approach to resect such a lesion has not been reported.

Laparoscopic management of a solitary non-neoplastic cyst arising within a bile duct hamartoma

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Aim: To describe a case of the successful laparoscopic management of a giant, symptomatic left lobe non-neoplastic cyst arising within a bile duct hamartoma (von Meyenburg complex).
Case Report: A 55-year old female had been having epigastric pains exacerbated by eating and upon lying down. She also admitted to several episodes of vomiting in association with the attacks of pain. An outpatient ultrasound during follow-up showed a thick walled cystic mass in the left upper quadrant. A computed tomography scan revealed an 8.5 x 10.2 x 9.0 cm thin walled non-enhancing cystic mass lateral to the gastric fundus. It could not be separated from the left lobe of the liver. Splenic or gastric origin could not be excluded. Magnetic resonance imaging was also unable to clearly delineate the origin of the mass. The patient had laparoscopic evaluation of the mass, which revealed a hepatic origin and subsequent laparoscopic resection resolved the diagnostic dilemma. There was an uneventful recovery. Histology revealed a solitary non-neoplastic cyst arising within a bile duct hamartoma (von Meyenburg complex).
Conclusion: This was an unusual presentation of a rare, benign malformation of the biliary tract, which is usually discovered at autopsy or erroneously confused with metastasis or other cystic hepatic lesions. Bile duct hamartomas appear radiologically indistinguishable from cystadenomas or other lesions, with the potential for malignant transformation leading to various degrees of hepatic resection. They are usually 1−2 cm in diameter and only rarely present as large as 10 cm. The definitive diagnosis was obtained only after laparoscopic resection and histologic

examination and represents the only means available of confirming the diagnosis. The laparoscopic approach therefore is a formidable weapon in the armamentarium of the surgeon faced with diagnostic challenges.