# Section 5

**Pathologic factors affecting gastric cancer survival at the University Hospital of the West Indies**

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**Objective:** To describe the survival of subjects with gastric adenocarcinoma (GA) post surgery at the University Hospital of the West Indies (UHWI) and the pathologic factors affecting survival.
**Method:** All patients having surgery for GA at the UHWI during the period January 1, 2000 to December 31, 2010 were enrolled and their pathology reports extracted. Other forms of gastric cancers such as endocrine tumours and oesophageal cancers were excluded from this series. Patients having a final pathologic diagnosis of GA at UHWI but with gastric surgeries done at an outside institution were also excluded. Data were analysed using STATA 9. Cox Hazard regression was used to model survival and the risk factors for death post surgery.
**Results:** A total of 79 patients with a median age of 67 years had resection for GA. Females accounted for 54.4%. Gastric adenocarcinoma was confined to the mucosa in 3.8% of patients and involved the subserosa or serosa in 91% of patients. The median tumour size was 6 cm with a range of 26.5 cm. A positive tumour margin was present proximally in 11.8% and distally in 15.8%. A median of eight nodes was removed (min = 0, max = 28): the median number of nodes positive for metastasis was two with a range of 22. Patients were followed for a total of 1912 person-months during which time there were 30 deaths, yielding an incidence rate of death of 18.8% per person-year (95% CI 0.132, 0.269). The median survival time was 70 months and this was affected by tumour involving the circumference of the stomach ($p = 0.0370$), tumour involvement of the serosa ($p = 0.017$) and venous invasion ($p = 0.055$). Age, tumour size, number of nodes removed, number of nodes positive and whether the patient had total gastrectomy did not affect survival in this cohort.
**Conclusion:** Survival of patients with GA at UHWI is affected by serosal and circumferential stomach involvement of the tumour and venous invasion.

**Management outcomes of facial nerve tumours: comparative outcomes with observation, CyberKnife, and surgical management**

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**Objectives:** Primary facial nerve tumours (FNTs) present in varying ways. In this study, the authors present their institutional experience with the management of facial nerve tumours, including their recommendations for available therapies such as observation, microsurgical decompression or removal, and stereotactic radiation. They emphasize the auditory and facial nerve function outcomes.
**Design:** A retrospective review of all cases of FNT seen at a tertiary care academic medical centre over a 10-year period (2002–2011) was conducted. The clinical presentation, treatment modality and outcome parameters of cochlear and facial nerve function were assessed.
**Results:** Twelve patients were identified. House-Brackmann grades on presentation were four grade I, two grade II, two grade III, one grade IV, and three grade V, with two grade V patients declining to grade VI shortly after presentation. Seven patients presented with serviceable hearing and four with nonserviceable hearing. Treatment options/arms included observation with serial clinic-radiological review (two cases), stereotactic radiation with the CyberKnife (three cases), wide fallopian canal decompression (three cases), microsurgical excision and repair (three cases) and biopsy followed by observation (one case). At the end of the review period, facial nerve function was stable in eight patients, improved in three, and declined in one; none had documented worsening of hearing based on the

American Academy of Otolaryngology–Head and Neck Surgery Foundation classification.
**Conclusions:** Management of FNT is largely based on the clinicoradiological picture. Each treatment arm is different, but overall auditory and facial function can be maintained.

**Post-cholecystectomy syndrome: a series of completion cholecystectomies using a laparoscopic approach**

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**Aim:** The incidence of incomplete cholecystectomies, whether intentional or inadvertent, remains unknown in the Caribbean. Retained or recurrent stones in the remnant gallbladder may produce the post-cholecystectomy syndrome. We report a series of three cases requiring completion cholecystectomies.
**Methods:** An audit of all patients requiring completion cholecystectomy for post-cholecystectomy syndromes was performed across the Anglophone Caribbean over a five-year period from January 1, 2008 to January 1, 2013. Retrospective chart review was performed to extract the following data: patient demographics, diagnoses, presenting complaints, operative details, morbidity, mortality and clinical outcomes. Descriptive statistics were generated using SPSS version 12.0.
**Results:** Laparoscopic completion cholecystectomies were performed in three patients (two women) with an average age of 56.3 years, SD ± 4.1, range 52–60. Two patients had the original cholecystectomy done electively through an open approach and one had an emergent laparoscopic cholecystectomy for acute cholecystitis. The completion cholecystectomies were all completed laparoscopically in 125 ± 5 minutes, without any conversions, morbidity or mortality.
**Conclusion:** Recurrent symptoms from a post-cholecystectomy syndrome should be entertained when patients return with recurrent symptoms post-cholecystectomy. The operations can be performed successfully using the laparoscopic approach in centres with advanced laparoscopic experience.

**Establishing a male health clinic in sickle cell disease**

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Sickle cell disease occurs with a frequency of 1 in 300 births in Jamaica. The urological manifestations of sickle cell disease include haematuria, renal medullary carcinoma and nocturnal enuresis. In addition, male patients with sickle cell disease may develop hypogonadism, infertility, priapism and erectile dysfunction. Priapism, perhaps the commonest complication in Jamaican men with sickle cell disease, considerably increases the risk of erectile dysfunction. Other causes for erectile dysfunction in sickle cell disease include hypogonadism. The exact aetiology and pathophysiologic mechanisms of the urological manifestations of sickle cell disease continue to evolve. Therefore, a male urological research clinic for sickle cell disease was established in April 2011 at the Sickle Cell Unit, The University of the West Indies, Jamaica. Preliminary data from the male urologic research clinic suggest that erectile dysfunction, priapism and premature ejaculation are the commonest diagnoses seen. We aim to recruit increasing numbers of patients to continue to define male sexual disorders in sickle cell disease.