1- Endoscopic management of postoperative bile duct injuries: a single center experience.

BACKGROUND/AIM: Biliary endoscopic procedures may be less invasive than surgery for management of postoperative bile duct injuries (POBDI). This retrospective work presents the experience of a single referral center during a period of 14 years in endoscopic management of POBDI. MATERIALS AND METHODS: Between 1994 (March) and 2008 (May), ERCP had been performed on 277 patients suspected to have POBDI. Patients shown to have complete transaction of bile duct were prepared for definitive surgery. For patients with simple biliary leak, sphincterotomy was performed with stenting. Pneumatic dilatation and stenting were done on patients with biliary stricture and preserved ductal continuity. ERCP was repeated every 3 months till the site of narrowing disappeared. RESULTS: The mean age was 45.3 years, 162 (58.5%) were females. The most common previous surgery was cholecystectomy (open, [N=119] 44%, and laparoscopic, [N=77] 28%). ERCP failed in 17 patients (6.1%). For successfully cannulated cases (N=260, 93.9%), the type of bile duct injury diagnosed at ERCP was completely ligated CBD (N=31/260 , 11.9%). Bile leakage was detected in (N=167/260, 64.2%) all patients with endoscopic sphincterotomy and stent insertion, the leak stopped in all of them. Biliary stricture was diagnosed in 33/260 patients (12.7%) and 17 of them had repeated balloon dilatation with stenting while the remaining had surgical correction. The success rate of endoscopic therapy for biliary strictures was 82%. Cholangiogram was normal in 29 patients (11.2%). CONCLUSIONS: Endoscopic therapy is safe and effective in the management of postoperative bile duct leak. For postoperative bile ductal strictures, ERCP is a less favorable option.

2- Is the use of T tube necessary after laparoscopic choledochotomy?

BACKGROUND: Traditionally, the common bile duct (CBD) is closed with T-tube drainage after choledochotomy and removal of CBD stones. However, the insertion of a T-tube is not without complication. AIM OF WORK: This randomized study was designed to compare the use of T-tube and primary closure of choledochotomy after laparoscopic choledochotomy to determine whether primary closure can be as safe as closure with T-tube drainage.

METHODS: Between February 2006 and June 2009, 122 consecutive patients with proven choledocholithiasis had laparoscopic choledochotomy. They were randomized into two equal groups: T-tube (n = 61) and primary closure (n = 61). Demographic data, intraoperative findings, postoperative complications, and postoperative stay were recorded.

RESULTS: There was no mortality in both groups. There were no differences in the demographic characteristics or clinical presentations between the two groups. Compared with the T-tube group, the operative time and postoperative stay were significantly shorter and the incidences of overall postoperative complications and biliary complications were statistically and significantly lower in the primary closure group.
CONCLUSION: Laparoscopic common bile duct exploration with primary closure without external drainage after laparoscopic choledochotomy is feasible, safe, and cost-effective. After verification of ductal clearance, the CBD could be closed primarily without T-tube insertion.

3-

**Endoscopic management of postoperative bile duct injuries**

**BACKGROUND/AIM:** Biliary endoscopic procedures may be less invasive than surgery for management of postoperative bile duct injuries (POBDI). This retrospective work presents the experience of a single referral center during a period of 14 years in endoscopic management of POBDI.

**MATERIALS AND METHODS:** Between 1994 (March) and 2008 (May), ERCP had been performed on 277 patients suspected to have POBDI. Patients shown to have complete transaction of bile duct were prepared for definitive surgery. For patients with simple biliary leak, sphincterotomy was performed with stenting. Pneumatic dilatation and stenting were done on patients with biliary stricture and preserved ductal continuity. ERCP was repeated every 3 months till the site of narrowing disappeared.

**RESULTS:** The mean age was 45.3 years, 162 (58.5%) were females. The most common previous surgery was cholecystectomy (open, [N=119] 44%, and laparoscopic, [N=77] 28%). ERCP failed in 17 patients (6.1%). For successfully cannulated cases (N=260, 93.9%), the type of bile duct injury diagnosed at ERCP was completely ligated CBD (N=31/260, 11.9%). Bile leakage was detected in (N=167/260, 64.2%) all patients with endoscopic sphincterotomy and stent insertion, the leak stopped in all of them. Biliary stricture was diagnosed in 33/260 patients (12.7%) and 17 of them had repeated balloon dilatation with stenting while the remaining had surgical correction. The success rate of endoscopic therapy for biliary strictures was 82%. Cholangiogram was normal in 29 patients (11.2%).

**CONCLUSIONS:** Endoscopic therapy is safe and effective in the management of postoperative bile duct leak. For postoperative bile ductal strictures, ERCP is a less favorable option.

4-

**Self expanding metal stents in palliation of malignant dysphagia**

Most cases of esophageal carcinoma are inoperable at presentation. Currently, the best method for palliation of malignant dysphagia, with or without esophago-respiratory fistula, is an insertion of esophageal self-expanding metal stents (SEMS) across the malignant esophageal stricture. Herein we present our experience in the use of SEMS in palliation of patients with malignant dysphagia and/or ERF. The study included 124 patients (79 males and 45 females) with advanced esophageal malignancy. The mean age was 54 (43-87) years. Nine patients had malignant ERF. All patients were subjected to SEMS insertion under both endoscopic and fluoroscopic guidance. SEMS insertion was successful in all patients. Nine patients had two stents. Median dysphagia score improved from 3.5 to 1.2. ERF was sealed in eight out of the nine patients. Complications related to stent implementation were reported in 41 patients. In conclusion, insertion of the SEMS
is a reliable, effective, simple and safe method for palliation of malignant dysphagia with or without ERF.

5-

Preoperative versus intraoperative endoscopic sphincterotomy for management of common bile duct stones

BACKGROUND:
ERCP remains the prevailing method of treating CBDS; however, its ideal timing in respect to laparoscopic cholecystectomy (LC) is not defined. LC combined with intraoperative endoscopic sphincterotomy (IOES) was compared with preoperative endoscopic sphincterotomy (PES) followed by LC for management of preoperatively known cholecystocholedocholithiasis.

METHODS:
Between June 2006 and September 2009, 198 patients diagnosed preoperatively by clinical assessment, liver chemistry, ultrasonography, and magnetic resonance cholangiopancreatography (MRCP) to have combined choledochocystolithiasis were eligible. They were randomly divided into two groups: PES/LC group (n = 100) and LC/IOES group (n = 98). The surgical times, surgical success rates, number of stone extractions, postoperative complications, retained common bile duct stones, and postoperative lengths of stay were compared prospectively.

RESULTS:
There were no statistically significant differences in surgical time, surgical success rate, CBD diameter, stone size, or stone number between the two groups. The success rate was 95.3% and 97.8% for PES/LC and LC/IOES, respectively. There were no significant difference in postoperative retained stones, surgical time, and complications, but the total hospital stay was significantly shorter in the LC/IOES group.

CONCLUSIONS:
PES/LC and LC/IOES are both good options for dealing with preoperatively diagnosed CBDS, but when there is enough experience and facilities, LC/IOES, as a single-stage treatment, would be preferable.

6-

Laparoendoscopic Management of Concomitant Gallbladder Stones and Common Bile Duct Stones

Abstract
BACKGROUND AND STUDY AIMS:
The intraoperative use of endoscopic retrograde cholangiopancreatography (ERCP) during laparoscopic cholecystectomy (LC) is a safe, single-stage option for the management of concomitant gallstones (GS) and common bile duct stones (CBDS). This study aims to compare between 2 techniques of combined laparoendoscopic management, which are laparoendoscopic Rendez-vous (LC/LERV) technique and standard ERCP after the completion of LC intraoperative endoscopic sphincterotomy (IOES).

PATIENTS AND METHODS:
Patients with GS and suspected CBDS were included. They were divided into 2 groups; LC/LERV and LC/IOES. Both groups were compared for failure of endoscopic sphincterotomy/stone extraction, operative time, conversion rate, mortality/morbidity,
RESULTS:
Between October 2007 and February 2010, 98 patients with GS and CBDS were eligible for inclusion in the study. They were prospectively randomized into 2 groups; LC/LERV (N=45) and LC/IOES (N=53). There were no differences in preoperative parameters between both groups. There was a significant difference in operative time (shorter for LC/IOES). No difference was noted in success/failure rate, post-ERCP pancreatitis. CONCLUSIONS:
Both Standard ERCP after the completion of LC and LC/LERV are valid single-session management for CBD stones, but LC-ERCP may be preferred.

7-
**Pelvic floor dyssynergia: Efficacy of biofeedback training**

Abstract  
**BACKGROUND AND STUDY AIMS:**  
Paradoxical contraction of the pelvic floor during attempts to defaecate is described as pelvic floor dyssynergia (anismus). It is a behavioural disorder (no associated morphological or neurological abnormalities); consequently, biofeedback training has been recommended as a behavioural therapy for such a disorder. The aim of the present study was to evaluate long-term satisfaction of patients diagnosed with pelvic floor dyssynergia after biofeedback. **PATIENTS AND METHODS:**  
Sixty patients (35 females and 25 males) with a mean age of 30±1 years and a 4 year duration of constipation were included. Forty-five patients had normal colonic transit and 15 patients had slow colonic transit. History, physical examination and barium enema were done to exclude constipation secondary to organic causes. Colonic and pelvic floor functions (colon-transit time, anorectal manometry, EMG and defaecography) were performed before and after biofeedback treatments. Patients were treated on a weekly basis with an average of (6±1) sessions. **RESULTS:**  
At the end of sessions, 55 out of 60 patients (91.6%) reported a subjectively overall improvement. Symptoms of dyschezia were reported less frequently after biofeedback. Age and gender were not predictive factors of outcome. No symptoms at initial assessment were predictive for patient’s satisfaction but the only factor of predictive value was the diagnosis of anismus and the motivated patient who wanted to continue the sessions. **CONCLUSION:**  
Biofeedback remains a morbidity free, low-cost and effective outpatient therapy for well-motivated patients complaining of functional constipation and diagnosed as pelvic floor dyssynergia.

8-
**Surgical management of gastric gastrointestinal stromal tumour**

Abstract  
**BACKGROUND/AIM:**  
Gastrointestinal stromal tumors (GISTs) are the most common mesenchymal tumors of the gastrointestinal tract. Surgery remains the mainstay of curative treatment. Our
objective is to evaluate the outcome of surgical treatment of primary gastric GIST.

MATERIALS AND METHODS:
Between January 1997 and April 2008, thirty seven consecutive patients underwent resection for GISTs (35 patients with primary gastric GISTs and two patients with intestinal GISTs who were excluded from the study). These patients underwent upper endoscopy ± biopsy, barium meal and abdominal CT scan. Patients’ demographics and clinical presentations were analyzed. Perioperative parameters measured included operative times, estimated blood loss, intraoperative finding, surgical techniques, morbidity and length of hospitalization. Recurrence and survival were also analyzed.

RESULTS:
Of the 35 patients with gastric GISTs included in the study, 63% were female. The median age was 59 ±14 years (range, 23 to 75 years). The primary presenting symptoms were bleeding and dyspepsia; 43% of these tumors were located mainly in the body of the stomach. Tumor size was < 10 cm in 80% of the patients. The average tumor size was 6.3 ±3.2 cm (range from 3 to 13 cm). Regarding the surgical management, 20 patients (57%) underwent gastric wedge resection, eight patients (23%) underwent partial gastrectomy and the remaining seven patients (20%) underwent total gastrectomy. Radical resections were found in 32 patients (91.5%) while palliative resections were found in three patients (8.5%). The resected lymph nodes were negative in 32 patients (91.5%). Recurrence was noted in three patients, with a median time to recurrence of 14.3 months (range, 7 to 28 months). The three- and five-years survival in patients who underwent wedge resection was 92% and 81%, respectively, where it was 95% and 87%, respectively, in patients who underwent gastrectomy (either partial or total). There were no major intraoperative complications or mortalities.

CONCLUSION:
Complete surgical resection either through wedge resection or gastrectomy with negative margins remains the gold standard treatment in the management of patients with primary resectable gastric GISTs.

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Post-cholecystectomy biliary injuries:

Abstract
BACKGROUND/AIMS:
Post-cholecystectomy bile duct injuries (BDIs) represent a challenge in diagnosis and management.

METHODOLOGY:
From March 1995 to August 2009, 274 patients with post-cholecystectomy BDIs were managed at our center. All patients were subjected to laboratory tests, sonography, ERCP and MRCP. The management varied according to the type of injury.

RESULTS:
Seventy-one (25.9%) LC and 203 (74.1%) OC were performed; 8 (2.9%) were detected intraoperatively; 270 patients were referred from other hospitals. From those discovered intraoperatively, 7 had hepatico-jejunostomy and one died from severe peritonitis; 11 (4%) presented with generalized and 112 (40.9%) with localized peritonitis. The leak site was the cystic duct (57 cases), accessory duct in the liver bed (5 cases), right hepatic duct (4 cases) and lateral tear in the CBD (12 cases). Endoscopic stenting was performed for all of them. The remaining 34 patients had a completely ligated distal duct and therefore
had hepatico-jejunostomy Roux loop; 143 patients (52.2%) presented with early (79 cases) and late (64 cases) jaundice; 126 cases had hepatico-jejunostomy. The remaining 17 patients were treated by balloon dilatation.

CONCLUSIONS:
Endoscopic stenting can manage cases with cystic or accessory duct leak while, hepatico-jejunostomy Roux loop represents the golden procedure for management of transected or ligated CBD.

10-
**Single incision laparoscopic cholecystectomy using harmonic scalp**

**JSingle-Incision Laparoscopic Cholecystectomy (SILC) Using Harmonic Scalpel. El-Geidie AA.**

SourceDepartment of General Surgery, Gastroenterology Surgical Center, Mansoura University, Mansoura, Egypt.

**Abstract**

BACKGROUND: Single-incision laparoscopic cholecystectomy (SILC) is emerging as a potentially less invasive alternative to standard laparoscopic cholecystectomy (LC). However, this procedure is technically more complex and time consuming. We present our initial experience with SILC using harmonic ACE (HS-SILC) in an attempt to simplify the procedure.

**METHODS:** We collected concurrent data on 67 consecutive patients undergoing HS-SILC by a single surgeon in a university-affiliated hospital over a period of 9 mo.

**RESULTS:** From May 2010 to February 2011, 67 consecutive patients underwent an attempted HS-SILC for symptomatic cholelithiasis by a single surgeon, with a success rate of 95.5%. Conversion to a standard LC was necessary in two patients (2.9%), and conversion to an open cholecystectomy was necessary in one patient (1.6%). The average operative time was 36.2 min. No injuries to the common bile duct occurred. Postoperative port site infection occurred in one patient (1.5%). No perioperative deaths occurred.

**CONCLUSIONS:** HS-SILC is safe and feasible. It simplifies the procedure and makes operative time less with better cosmetic results and lower rate of conversion to multi-incision LC or open cholecystectomy

11-
**Laparoscopic Exploration versus Intraoperative Endoscopic Sphincterotomy for Common Bile Duct Stones:**

**Background/Aims:** Laparoscopic cholecystectomy (LC) combined with intraoperative endoscopic sphincterotomy (IOES) was compared to LC with laparoscopic common bile duct exploration (LCBDE) to define the best single-session minimally invasive treatment for cholecystocholedocholithiasis.

**Methods:** Between June 2009 and December 2010, patients with gallstones and common bile duct (CBD) stones diagnosed by preoperative ultrasonography and magnetic
resonance cholangiopancreatography were randomized to LC-LCBDE or LC-IOES. The primary end point was complete clearance of CBD of stones. The secondary end points were operation time, conversion rate, length of hospital stay, complications and mortality. Results: Two hundred and twentysix patients were eligible. They were randomized to LCLCBDE (n = 115) and LC-IOES (n = 111). There was no statistically significant difference in the success rate of CBD clearance between the two interventions (92% for LC-LCBDE vs. 97.2% for LC-IOES with a p value 1 0.05). There were no differences between the two groups in terms of surgical time and postoperative length of stay. Pancreatitis and bleeding sphincterotomy were significantly more prevalent in the LCIOES group, while bile leakage and retained CBD stones were significantly more prevalent in the LC-LCBDE group. Conclusion: Both LC-IOES and LC-LCBDE were shown to be safe, effective, minimally invasive treatments for cholecystocholec docholithiasis, but the former option may be preferred when facilities and experience in endoscopic therapy exist.

12-
Pancreatic Cystic Neoplasms: Predictors of Malignant Behavior and Management

Background/Aim: Pancreatic cystic neoplasms are being increasingly identified with the widespread use of advanced imaging techniques. In the absence of a good radiologic or pathologic test to preoperatively determine the diagnosis, clinical characteristics might be helpful. The objectives of this analysis were to define the incidence, and predictors of malignancy in pancreatic cysts. Patients and Methods: Patients who had true pancreatic cysts treated at our institution were included. Patients with documented pseudocysts were excluded. Demographic data, clinical manifestations, radiological, surgical, and pathological records were reviewed for these patients. Results: Eighty‑one patients had true pancreatic cyst. The mean age was 47 15.5 ±1 years. There were 28.4% serous cystadenoma, 21% mucinous cystadenoma, 6.2% intraductal papillary tumors, 8.6% solid pseudopapillary tumors, 1.2% neuroendocrine tumor, 3.7% ductal adenocarcinoma, and 30.9% mucinous cystadenocarcinoma. Malignancy was significantly associated with men (P = 0.04), older age (0.0001), cysts larger than 3 cm in diameter (P = 0.001), presence of solid component (P = 0.0001), and cyst wall thickening (P = 0.0001). The majority of patients with malignancy were symptomatic (26/28, 92.9%). The symptoms correlated with malignancy included abdominal pain (P = 0.04) and weight loss (P =
Surgical procedures depended on the location and extension of the lesion. Conclusion: The most common pancreatic cysts were serous and mucinous cysts. These tumors were more common in females. Old age, male gender, large tumor, presence of solid component, wall thickness, and presence of symptoms may predict malignancy in the cyst.

Key Words: Cystadenocarcinoma, cystadenoma, enucleation, pancreatic cyst, pseudocyst

Laparoscopic Heller Myotomy For Achalasia: Analysis of Successes And Failures. Hepato-Gastroenterology 2012; 117:1450-1454

BACKGROUND/AIMS:
The outcome of laparoscopic myotomy for achalasia is dictated by many factors.

METHODOLOGY:
A retrospective study was conducted between 1997-2007, 58 patients who fulfilled all criteria for the diagnosis of achalasia underwent laparoscopic Heller myotomy and 45 (77.6%) were included. Mean follow-up period was 3615±1 months; 56 patients had Dor fundoplication; 17 patients had been previously treated by pneumatic dilatation. All steps of the procedure, esophageal manometric findings and radiological records were analyzed to determine factors contributing to the clinical success or failure of the operation. The main outcome measure was swallowing status.

RESULTS:
Median hospital stay was 31±1 days and mean operative time was 7520±1 min. There were 7 intra-operative mucosal injuries; all sutured laparoscopically (5 had previous pneumatic dilatation). Good or excellent relief of dysphagia was obtained in 41 patients and was persistent among 2 patients (both had pneumatic dilatation preoperatively). The remaining 2 patients developed gastroesophageal reflux symptoms. These 41 patients had a preoperative smaller diameter of the esophagus (stage I, II and III), while those with guarding results (4) had stages III and IV. There was a decrease in LES pressure from 457±1 mmHg to 102±1 mmHg without evidence of restoration of esophageal peristalsis in any patient.

CONCLUSIONS:
Laparoscopic Heller myotomy with Dor fundoplication significantly relieves the symptoms of achalasia without causing the symptoms of gastroesophageal reflux disease. A good postoperative result is expected when the length of myotomy is adequate, LES pressure declines substantially, preoperative esophageal dilatation is not excessive and distortion of the distal esophagus is absent.

Staplerâ€™s malfunction during laparoscopic sleeve gastrectomy: an unusual but correctable complication. Surgery for Obesity and Related Diseases 9 (2013) 144â€“146
The number of laparoscopic sleeve gastrectomies (LSGs) performed annually as a primary bariatric procedure has significantly increased all over the world [1,2]. According to many published studies, LSG has proved to be well tolerated and effective, with a significant reduction of obesity-related co-morbidities [3â€“5]. The key factors for the worldwide acceptance of LSG as a standalone bariatric procedure are not only its safety profile and efficacy but also its simplicity compared with other bariatric procedures such as laparoscopic Roux-en-Y gastric bypass and duodenal switch. However, LSG is not devoid of complications, such as leakage, bleeding, and stenosis. In LSG, the surgeon depends on staplers for creation of a small gastric tube, but these staplers sometimes have mechanical problems and malfunction.

**Pancreatic Anastomotic Leakage after Pancreaticoduodenectomy. Risk factors, Clinical predictors, and Management (Single Center Experience).**

Abstract

BACKGROUND: Postoperative pancreatic fistula (POPF) after pancreaticoduodenectomy (PD) remains a challenge even at high-volume centers.

METHODS: This study was designed to analyze perioperative risk factors for POPF after PD and evaluate the factors that predict the extent and severity of leak. Demographic data, preoperative, intraoperative, and postoperative variables were collected.

RESULTS: A total of 471 consecutive patients underwent PD in our center. Fifty-seven patients (12.1 %) developed a POPF of any type; 21 patients (4.5 %) had a fistula type A, 22 patients (4.7 %) had a fistula type B, and the remaining 14 patients (3 %) had a POPF type C. Cirrhotic liver (P = 0.05), BMI > 25 kg/m(2) (P = 0.0001), soft pancreas (P = 0.04), pancreatic duct diameter 4,000 IU/L, WBC, pancreatic duct diameter

CONCLUSIONS: Cirrhotic liver, BMI, soft pancreas, pancreatic duct diameter 4,000 IU/L on POD 1 and 5, WBC, pancreatic duct diameter, pancreatic texture may be predictors of POPF B, C.