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POSTER

Missed abdominal oncological diseases during laparoscopic cholecystectomy

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Background: One of lacks of videolaparoscopic cholecystectomy is the absence of manual exploration of abdominal cavity with the purpose of revealing of a possible concomitant pathology. The opportunities of the visual control and palpation of organs by manipulators for diagnostics of oncological diseases are limited.

Methods: Follow-up of 3000 laparoscopic cholecystectomies has shown 10 cases (0.3%) of missed oncological diseases, when the patients were operated on after laparoscopic cholecystectomy in terms from 4 months till 1 year. Among observed were 3 men and 7 women in the age from 42 till 80 years. The stenosing cancer of a stomach was revealed in 1 patient, the tumour of hepatic flexure of the colon in 2, the tumor of the head of the pancreas in 2, tumor of common bile duct in 1, cancer of endometrium in 1, cancer of the caecum in 2, cancer of the low third of the rectum in 1 patient. Retrospective study of case reports revealed that all the patients were subjected only to the ultrasonic research of abdominal cavity. However, analysis of the complaints of the patients exposed that in 8 of 10 cases there were symptoms of abdominal discomfort characteristic to stomach and colon ailment and not typical to clinical picture of gallstone disease.

Results: All patients were operated on by using laparotomy. Partial distal gastrectomy was carried out in 1 patient, right hemicolectomy in 4, gysterectomy in 1, abdomino-perineal extirpation of the rectum in 1, biliodigestive shunt in 3. Postoperative course in all patients was uneventful.

Conclusion: The prophylaxis of missed oncological pathology during laparoscopic cholecystectomy consist in more thorough preoperative investigation of the patients with gallstone disease. In patients senior than 40 years, it is advisable alongside with ultrasonic research of abdominal cavity to carry out endoscopic exploration of a stomach and colon and in women it is highly recommended to perform complete gynecological inspection.

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Surgical treatment of bilobar hepatic metastases

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Background: Bilobar hepatic metastases represent one of the greatest challenges in surgical treatment of metastatic disease. 20% of patients with hepatic metastases have bilobar hepatic metastases. During the last decade significant technical achievements made radical surgical procedures safer. In R0 resection 5-year survival is between 13% and 28% depending on various prognostic factors.

Surgical strategy for hepatic resection must satisfy two contradictory goals:

1. To accomplish metastases free resectional margins
2. To preserve as much as possible hepatic parenchyma for normal liver function and maybe for future resections

Material and methods: Combining hepatic resection (CUSA) and radio-frequency ablation (RADIONIX) we managed to satisfy both oncological radicality and preservation of sufficient amount of healthy liver parenchyma. We use this technique if there is a large metastatic lesion in one of the lobes needed to be resected and one or more lesions in the opposite lobe which if resected would compromise function of spared liver. During the period 2002 till the August 2004, we had 57 patients with bilobar hepatic metastases where we performed combine treatment – **resection + ablation**. 30 patients had colon and rectum metastases; 27 patients with metastases from other origin.

Results: There were no intra- and postoperative mortalities. 5 patients were febrile on the 4th postoperative day. Two patients died in the period of 6 to 8 months after surgery. Three patients died year after resection. Two patients have died from extra hepatic disease and three from multiple liver recurrence. Two patients had recurrent liver disease after one year and were reoperated radically once again and they are still alive. Till now all other patients are still alive without recurrence on the liver

Conclusion: Surgical treatment of metastases should be applied whenever possible. Combined approach allows removal of metastases with preservation of sufficient amount of liver parenchyma. Combined approach represents a safe method in the treatment of metastatic liver disease

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POSTER

The safe and reliable method of duct to mucosa pancreaticojejunostomy and extremely favorable results of 50 consecutive cases.

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Background: There is a high risk of anastomotic leakage after pancreaticojejunostomy. Pancreatic anastomotic leakage often results in severe complications of sepsis, intra-abdominal bleeding, pancreatic fistula, and is a significant cause of morbidity and mortality. An appropriate technique to minimize pancreatic leakage is very important. Recently we have performed duct to mucosapancreaticojejunostomy with resection of jejunal serosa and obtained positive results.

Patients and methods: During 1999–2005, 50 patients (24 female, 26 male) underwent duct to mucosa pancreaticojejunostomy with resection of jejunal serosa after pancreatic head resections for benign (n=5) and malignant disease (n=45). The mean age was 64.1 years (range 33–80).

Results: Mean post-operative hospital stay was 32.2 days. Morbidity rate due to early postoperative complication was 4% (pulmonary embolism in 1, pneumothorax in 1), with no pancreatic leakage.

Conclusions: There were low complication rate and an absence of pancreatic anastomotic leakage that occurred with 50 consecutive patients who underwent duct to mucosa pancreaticojejunostomy with resection of jejunal serosa. We consider that this pancreatic anastomotic technique is extremely favorable for pancreaticojejunostomy.

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Factors influencing breath functions of oncology patients after thoracoscopic surgery

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The purpose of the research was to study the factors influencing breath of oncology patients who underwent thoracoscopic surgical procedure.

We evaluated breath functions of 30 patients before and 3 days after thoracoscopic surgery (21 lung resections, 9 tumour biopsies) using Flowscreen Pro spirometry (Jaeger, Germany) and ABL-520 blood gas analyser (Radiometer, Denmark). On average, procedures lasted 34±8 minutes under general anaesthesia with pneumothorax on the side of the surgery. Generally, breath characteristics of all the patients before the procedure were at the lowest level but after the procedures VC and FVC reduced by 18.7%, PEF – by 24.2%, MEF₅₀ – by 16.9%, MVV – by 18.25%. Other breath parameters and blood gas concentration did not change. Age and invasion level (lung resection, biopsy) did not affect breath functions. However, reduction of the indicated parameters in the patients with initially disturbed breath functions (n=9) resulted in shortness of breath (II degree). Breath functions of patients with initially normal breath functions (n=21) were low but still within normal range. Thus, shortness of breath does not develop in the patients with initially normal breath after thoracoscopic surgery. At the same time, the risk of getting shortness of breath raises dramatically for the patients with initially low breath characteristics irrespective of age and invasion scale.

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The greater omentum in surgical treatment of radionecrosis in breast cancer patients

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The indications and techniques for surgical treatment of radionecrosis in breast cancer patients are presented. Surgical excision of radionecrotic tissues with reconstruction by well vascularised tissues is an effective mode of treatment. The flaps from neighbourhood (rotation or transposed) are good methods for wound covering after resection of ulceration. In case of breast cancer the thoracic wall defect may be covered by a flap of the opposite breast or latissimus dorsi (LD) flap. In case of large and deep radionecrosis involving whole thickness of thoracic wall the greater omentum flap is an optimal solution for reconstruction of the defect created after excision of postradiation necrotic tissues. The greater omentum has a very good blood supply, produces an angiogenic factor promoting proliferation of vessels to underlying tissues, is resistant to infection and skin flaps or free skin grafts heals on it very well.

The greater omentum can be transposed on the chest wall after dissection from transverse colon and stomach, leaving a pedicle containing the left or right gastroepiploic vessels.