Feasibility and efficacy of double over-the-scope clipping for colonic iatrogenic perforation

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Colo-rectal iatrogenic perforation is a rare complication in diagnostic colonoscopy, occurring in a range of 0.03%–0.8%. Risk factors comprehend endoscopist inexperience, female gender, peri-colic adhesions, inflammatory colonic diseases, severe diverticular disease, greater age due to weakened colonic wall tissues[1]. Over-the-scope clip (OTSC, Ovesco Endoscopy GmbH, Tübingen, Germany) is a useful tool, recommended as first-line endoscopic treatment for endoscopic acute iatrogenic perforation[1], which can avoid emergency surgical repair[2]. However, the deployment of OTSC may be in some cases challenging, due to the size, the position of the hole (i.e. sigmoid-rectal junction), the presence of other endoscopic devices (i.e. standard clip or OTSC) to completely close the defect. To the best of our knowledge, there’s not described the deployment of two adjacent OTSC.

Here we report the video-case of an 89-year-old woman referred to our unit to perform colonoscopy (CFHQ190L; Olympus Co., Japan), because of positive hemoccult test and anemia. Because of peri-colic adhesions in a picture of severe diverticular disease, a perforation of about 20-25mm occurred in the sigmoid-rectal junction. After positioning of naso-gastric tube and Verres needle to favour abdominal decompression, a preliminary deployment of OTSC (11/6 mm traumatic type) with suction technique didn’t achieve the complete seal of the defect. Indeed, another analogous OTSC was deployed with suction technique tightly adjacent to the first one, obtaining the total closure of the leakage, as confirmed at the injection of contrast medium and subsequent computed tomography scan (video). All the procedure was performed with anesthesiological assistance, using CO2 insufflation. No further complication occurred, broad spectrum antibiotics were administered and the patient was discharged asymptomatic 1 week later. In conclusion, even challenging, the closely deployment of two OTSCs is feasible and effective to treat iatrogenic perforations. Furthermore, it can avoid later complications or surgical repair, especially in high anesthesiological risk patients.

Biography
Paola Soriani is a young Gastroenterologist and digestive endoscopist. She’s very interested in digestive therapeutic endoscopy. Endoscopic performances and numbers: 3000 EGDS, 2500 colonoscopies, 500 therapeutic procedures in which she’s already in training (EMR, EFTR with FTRD System, dilation, deployment of clip, OTSC, Endosponge, ERCP, EUS, stent (esophageal, biliary, enteral), Zenker’s diverticulotomy), 50 urgency-emergency procedures. She has published 15 research articles and abstracts. She is member of the Italian Society of Digestive Endoscopy (SIED) and of the Italian Society of Gastroenterology (SIGE).

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Transanal endoscopic microsurgery for rectal lesions: outcomes from a tertiary referral centre.

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Transanal endoscopic microsurgery (TEMS) is a well-recognised modality for treating rectal lesions. The complications and recurrence rate varies significantly amongst different centres. The aim of this study was to assess TEMS outcomes at a tertiary referral centre for both benign and malignant lesions.

Patients and methods:
This was a retrospective analysis of a prospectively maintained data of all patients who underwent TEMS at Sheffield Teaching Hospitals between 2012 and 2015. Data included demographics, presentation, staging, complications and recurrence rate. Both benign adenomas and malignant lesions were included.

Results:
A total of 70 patients (63% male) were included with a median age of 68. Benign rectal adenomas were 46 (66%) while 23 (33%) were malignant. Commonest presentations were PR bleeding (46%) & tenesmus (22%). The polyp size was *3 (range 1.0- 8.5) cm. Mean length of operation was 30 (range 20-45) min. Length of stay was *1 day (1-4). There was no operative mortality. No recurrence was reported following excision of a benign adenoma. Three patients in whom the tumour was upgraded/ involved margins, underwent anterior resection. Post-op complications included bleeding 4(6%), incontinence 1(1.5%), stricture 2(3%) & retention 2(3%). No cancer-related deaths were observed during the follow-up period.

CONCLUSION:
Our study from demonstrates that TEMS excision is a safe and a feasible technique with a low recurrence rate and complications unlike the previously published data of 10% recurrence of benign polyps. It should be offered to both benign rectal tumors and selected early malignant neoplasms.

*median

Biography:
Khurram Siddique graduated from Rawalpindi Medical College (Punjab University) Pakistan in 2003. He completed his post-graduate surgical training from Holy Family Hospital, Rawalpindi and received his Membership followed by Fellowship of the College of Physicians & surgeons Pakistan in 2008. In pursuit of excellence in surgical skills, he continued his journey and came to U.K where he completed the Higher Surgical Training and is currently working as a senior registrar in Sheffield Teaching Hospitals U.K. He has also accomplished the membership (MRCS) as well as Fellowship of the Royal College of surgeons of England (FRCS). To further enhance his academia, received a Master’s degree in surgical practice from University of Kent. He has published number of articles in leading surgical journals and currently serves as a reviewer and an editorial member of many specialized peer-reviewed journals. He has presented his work both nationally and internationally and has won various prizes and awards. He is actively involved in teaching and training and has organised and developed various simulation courses. He is also a member of many surgical associations.
Laparoscopic spleen preserving distal Pancreatectomy: Feasible but importance of case selection

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Introduction:
Laparoscopic spleen preserving distal pancreatectomy requires considerable expertise in both pancreatic and laparoscopic surgery. Laparoscopic pancreatic surgery has shown real advantages during postoperative period.

Materials and Method:
We retrospectively studied series of 10 patients affected by solid and cystic tumors of tail pancreas. Laparoscopic spleen preserving distal pancreatectomy was performed in these 7 patients while laparoscopic distal pancreatico splenectomy in 3. Indications, technical procedure and postoperative outcome were recorded.

Results:
10 patients underwent laparoscopic spleen preserving distal pancreatectomy from May 2007- June 2017. All procedures were completed laparoscopically. There was one case of secondary haemorrhage in SPDP with documented pancreatic leak. There was no conversion. No patient required intraoperative blood transfusion. The average operative time was 155 ml. The average hospital stay was 5.6 days.

Conclusion:
Laparoscopy makes spleen preserving distal pancreatectomy feasible because of magnification and precision. Laparoscopic spleen preserving distal pancreatectomy can be performed in solid and cystic tumors of distal pancreas. The procedure should be performed by surgeons with expertise in pancreatic and laparoscopic surgery. Laparoscopic spleen preserving distal pancreatectomy resulted in reduced postoperative complications and hospital stay. Postoperative complication due to pancreatic leak is more in SPDP than distal pancreaticosplenectomy hence case selection is important.

Biography:
Geetanjali Agarwal Joshi is a practicing laparoscopic and robotic oncosurgeon with aditya Birla corporate hospital in Pune, India. She is a senior coordinator of the oncosurgical department. She has worked as an associate with a high volume academic centre galaxy care laparoscopy institute in India and till jan 2016. She has coauthored more than 30 publications and contributor for 2 textbooks and 2 surgical atlas.

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Laparoscopic resection of rectal cancer: Feasibility and safety

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Introduction:
Laparoscopic colectomy is a well established procedure however laparoscopic proctectomy for rectal cancer is technically more demanding. The challenges mentioned in literature are completeness of total mesorectal excision (TME), negative circumferential margins (CRM), deep and narrow pelvis, preservation of nerves and effects of neoadjuvant chemoradiation. The COREAN trial highlighted that laparoscopic approach was able to achieve comparable outcomes to open surgery in terms of surgical morbidity and mortality as well as oncological safety. But it showed surgical time was significantly higher in laparoscopic approach.

Technique and Results: The team members have assisted and performed more than 102 cases from 2009. The steps described in the procedure prevent repetition and is duplicable. The time taken for surgery is average 150 mins. Blood loss of around 150-200 ml. The leak rates and morbidity, completeness of TME, negative CRM and bowel bladder function were comparable to literature.

Conclusion:
Laparoscopic resection of rectal cancer is a feasible option and is oncologically safe.

Biography:
Saurabh Joshi is a practicing laparoscopic and robotic oncosurgeon with Aditya Birla corporate hospital in Pune, India. He is attached to various corporate hospitals in Pune. He has worked as an associate with a high volume academic centre galaxy care laparoscopy institute in India and till Feb 2016. He has coauthored more than 25 publications and contributor for 2 text books and 2 surgical atlas.
Combination of Sitagliptin and Silymarin ameliorates liver fibrosis induced by carbon tetrachloride in rats

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Liver fibrosis is a common pathological condition that occurs in most conditions associated with chronic liver injury. Silymarin is a herbal product widely used for its hepatoprotective effect. Sitagliptin, a dipeptidyl peptidase-4 inhibitor (DPP4-I), is clinically used as an oral antidiabetic agent. This study was designed to investigate the effects of Sitagliptin, Silymarin, and their combination on established liver fibrosis in carbon tetrachloride (CCl₄) rat model. Male albino rats received intraperitoneal injections of CCl₄ three times a week for 7 weeks, as well as daily oral treatments of Sitagliptin (100 mg/kg) or Silymarin (100 mg/kg) or their combination during the 7 weeks of intoxication. Hepatic fibrotic changes were evaluated by measuring hepatic enzymes (ALT, AST, ALP, and GGT) and markers of fibrosis (transforming growth factor β1 (TGF-β1), tissue 4-hydroxyproline level, histopathological score), oxidative stress (MDA, GSH, and NOx levels), inflammation (interleukin-6) as well as markers of HSCs activation (α-smooth muscle actin (α-SMA) expression). The injected rats with CCl₄ for 7 weeks resulted in a marked elevation of hepatic fibrotic changes and reduction of GSH level, while the combination therapy showed a significant decrease in the former one and a significant increase in the later. In conclusion, this study shows that the combination therapy is more beneficial than monotherapy in ameliorating liver fibrosis in rats. Our findings suggest that Sitagliptin alone or in combination with Silymarin may introduce a new strategy for treating liver fibrosis in humans.

Biography
Mai Elsayed has completed her bachelors from the Faculty of pharmacy at Alexanderia University. She is a pharmacist in liver institute in Kafr Elsheikh, Egypt. Also, she participated in the project of virus c treating people project in Egypt. She has one paper published in Biomedicine and pharmacotherapy journal.
Feasibility and safety profile of laparoscopic inguinal hernia repair with a modular mesh

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Introduction: The advantages of laparoscopic Inguinal hernia repair have been well known. Mesh migration has been a matter of great concern persuading surgeons to fix the mesh albeit associated with significant morbidity.

Objective: To determine the outcomes of patients undergoing laparoscopic inguinal hernia repair with or without mesh fixation.

Patients and Methods: This is a retrospective analysis of a prospectively maintained data base. All eligible adults who underwent hernia repair between Apr 14 to Mar 15 were included. Patient demographics, presentation, technique of repair, type of mesh +/- fixation, post-op complications, recurrence and readmission were calculated using SPSS 21.

Results: A total of 214 patients included 208(97%) males; rest were female with a mean age of 54. A total of 232 laparoscopic hernia repairs were performed with an equal number of TEP and TAPP. Symptomatic hernia was noted in 179(83%) with clinically palpable lump in 189(88%). Bilateral included 36(16%) while rest were unilateral. Most frequently used mesh was 3DMax™ (Normal and Light; BARD) in 116(54%) & 74(35%) cases respectively. Mesh was fixed in only 9(4%) cases with Pro Tacks or SorbaFix, rest were placed anatomically. There were no per-op complications, only one conversion (<1%) and two readmissions (1%). Two recurrences (1%) were noted in each of TEP and TAPP, both when the mesh was not fixed. Consultants and registrars performed 169(79%) and 45(21%) cases respectively without any difference in outcome. Post op pain was reported by six patients managed conservatively but no difference was noted in type of mesh or fixation method.

Conclusion: This specially designed mesh has the advantage of adapting to the contour of the groin helping in anatomical reconstruction and less risk of migration. Our study shows the efficacy of 3D MaxTM mesh and highlights that mesh fixation isn’t essential to prevent recurrence and is associated with minimum morbidity.

Biography
Khurram Siddique graduated from Rawalpindi Medical College (Punjab University) Pakistan in 2003. He completed his post-graduate surgical training from Holy Family Hospital, Rawalpindi and received his Membership followed by Fellowship of the College of Physicians & surgeons Pakistan in 2008. In pursuit of excellence in surgical skills, he continued his journey and came to U.K where he completed the Higher Surgical Training and is currently working as a senior registrar in Sheffield Teaching Hospitals U.K. He has also accomplished the membership (MRCS) as well as Fellowship of the Royal College of surgeons of England (FRCS). To further enhance his academia, received a Master’s degree in surgical practice from University of Kent. He has published many articles in leading surgical journals and currently serves as a reviewer and an editorial member of many specialized peer-reviewed journals. He has presented his work both nationally and internationally and has won various prizes and awards. He is actively involved in teaching and training and has organised and developed various simulation courses. He is also a member of many surgical associations.
TransAbdominal Sonography of the Small & Large Intestines

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TransAbdominal Sonography of the Small & Large Intestines can reveal following diseases. Bacterial & Viral Entero-Colitis. An Ulcer, whether it is superficial, deep with risk of impending perforation, Perforated, Sealed perforation, Chronic Ulcer & Post-Healing fibrosis & stricture. Polyps & Diverticulum. Benign intra-mural tumours. Intra-mural haematoma. Intestinal Ascariasis. Foreign Body. Necrotizing Entero-Colitis. Tuberculosis. Intussusception. Inflammatory Bowel Disease, Ulcerative Colitis, Crohn's Disease. Complications of an Inflammatory Bowel Disease – Perforation, Stricture. Neoplastic lesion is usually a segment involvement, & shows irregularly thickened, hypoechoic & aperistaltic wall with loss of normal layering pattern. It is usually a solitary stricture & has eccentric irregular luminal narrowing. It shows loss of normal Gut Signature. Enlargement of the involved segment seen. Shouldering effect at the ends of stricture is most common feature. Primary arising from wall itself & secondary are invasion from adjacent malignancy or distant metastasis. All these cases are compared & proved with gold standards like surgery & endoscopy. Some extra efforts taken during all routine or emergent ultrasonography examinations can be an effective non-invasive method to diagnose primarily hitherto unsuspected benign & malignant Gastro-Intestinal Tract lesions, so should be the investigation of choice.

Biography
Vikas Leelavati Balasaheb Jadhav has completed PostGraduation in Radiology in 1994. He has a 23 Years of experience in the field of Gastro-Intestinal Tract Ultrasound & Diagnostic as well Therapeutic Interventional Sonography. He is the Pioneer of Gastro-Intestinal Tract Sonography, especially Gastro-Duodenal Sonography. He has delivered many Guest Lectures in Indian as well International Conferences in nearly 27 countries as an Invited Guest Faculty, since March 2000. He is a Consultant Radiologist & the Specialist in Conventional as well Unconventional Gastro-Intestinal Tract Ultrasound & Diagnostic as well Therapeutic Interventional Sonologist in Pune, India.

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Laparoscopic assisted Transhiatal Esophagectomy: A feasible and safe option in selected cases

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Introduction: Surgical treatment remains the mainstay of treatment of localized esophageal cancer. Two major categories of approaches are described transthoracic and transhiatal. Relative improved 5-year survival seen probably because of improved surgical outcomes, progress in systemic chemotherapy and radiotherapy. As increase in GERD adenocarcinoma of GE junction have shown an increase in incidence. Laparoscopy has made transhiatal dissection more controlled and safe. Retrospective non-comparative series have shown no definitive advantage in oncological outcome or postoperative morbidity and mortality.

Technique: Laparoscopy has made transhiatal esophagectomy a feasible option with reduced morbidity and mortality. We describe laparoscopic assisted esophagectomy where stomach and esophagus are mobilized laparoscopically. Esophagus is disconnected from left sided cervical incision. Mini laparotomy done to deliver the specimen and an extracorporeal stomach tube is created with the help of staplers. Conduit railroaded through mediastinum and double layered end to side handsewn esophago gastric anastomosis done.

Discussion: In localized GE junction adenocarcinoma transhiatal esophagectomy is a recommended surgical approach. Complications of open THE include blood loss, anastomotic leaks and wound infections. Laparoscopy helps convert a blind dissection to visually assisted procedure resulting in better control and reduced blood loss. We have less anastomotic leak and we contribute it to reduced stomach handling ad congestion. Rate of wound infection reduced due to reduced size of incision and reduced tissue handling.

Conclusion: Lap THE can be performed in selected cases with reduced morbidity and mortality especially in patients with high pulmonary and cardiac risks.

Biography
Saurabh Joshi is a practicing laparoscopic and robotic oncosurgeon with Aditya Birla corporate hospital in Pune, India. He is attached to various corporate hospitals in Pune. He has worked as an associate with a high-volume academic centre galaxy care laparoscopy institute in India and till Feb 2016. He has coauthored more than 25 publications and contributor for 2 textbooks and 2 surgical atlas.

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