34th Annual Meeting of Egyptian Society of Surgeons

April 13-15, 2016
Semiramis Intercontinental Hotel

Abstracts included are those received before deadline

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**19- Panel X Non Traumatic Vascular Emergency**
Day 1: Wednesday April 13th, 2016

1-Session 1 Hepato-pancerato-biliary I

1) Retroperitoneal resection margin in cancer head pancreas

Background: Resection margin (RM) status in pancreatic head adenocarcinoma is assessed histologically, but pathological examination is not standardized. Our aim was to determine the influence of the “standardized histopathological workup” of pancreaticoduodenectomy specimens on the reporting of the RM status using a “surgical quality protocol”

Methods: Starting October 2009, 42 patients underwent pancreaticoduodenectomy using “surgical quality protocol” for pancreatic ductal adenocarcinoma and examined using “standardized histopathological workup”. We prospectively evaluated and validated its results for 50 month. We evaluated different sites of R1 at 0 mm and 1 mm resections according to the color code and demonstrate the most frequent site of incomplete tumor resection.

Results: Patient consisted of 14 females and 28 males. Their age ranged from 46 to 74 years with a median of 60 years. Changing to “standardized histopathological workup” from traditional pathological examination procedures resulted in an increase of the R1 rate from 14.3 to 64.3% in this prospective series. 15% of R1 resections exhibited multifocal margin involvement (i.e. more than one margin involved in a single specimen) for the 0mm in contrast to 33% for the 1.0mm margin. The uncinate margin represent the most frequent site with residual tumor mass by far (42% at 0mm and 43% at 1mm) followed by posterior margin. When R1 resection was defined by a positive margin of 0 mm, 48% of the present patients achieved R1 resection. In contrast to when R1 resection was defined by the presence of tumor cells within 1.0 mm 64%, of the present patients achieved R1 resection.

Conclusion: Standardization of the histopathological examination of pancreaticoduodenectomy specimens influences the reporting of RM status. The resection margin involvement is significantly more frequent than commonly reported. Complete and meticulous surgical resection of the uncinate process en bloc with all the preipancreatic tissues between the artery and the pancreatic parenchyma must become the standard surgical approach in pancreatic head resection as it is the most frequent site for residual tumor by far.

Ahmed El-Gendi
MD, MS, MRCS(Engl), PhD
Assistant Professor of Surgery
Consultant of HPB and Laparoscopic surgery
Faculty of Medicine University of Alexandria Egypt
2) **Liver trauma.**

Departments of General Surgery, Cairo University*, Theodore Bilharz Research Institute**

**Abstract**

**Introduction:** Liver trauma represents a significant challenge in management that requires a high index of suspicion, accurate investigation classification and well-defined management protocols.

**Aim of the work:** The purpose of this work is to review our experience of liver injuries regarding the available diagnostic modalities and current management options.

**Methods:** A Retrospective study including 42 injured patients with Liver trauma. Patients with associated major extra-abdominal injury were excluded from the study. After ABC resuscitation according to ALTS protocol; Patients were subjected to a through clinical, laboratory and radiological assessment.

**Results:** Patients were classified into Blunt and penetrating injuries 32 patients and 10 patients respectively. The management were classified into operative and non operative management according American Association for the Surgery of Trauma (AAST) classification system Liver trauma.

23 out of 32 patients with blunt liver injuries, has been managed conservatively Non Operative Management (NOM). The remaining 9 patients had operative management laparotomy and proceed. 4 out of 10 patients with penetrating liver injuries were treated conservatively (NOM). The remaining 6 patients had (laparotomy and proceed).

**Conclusion:** Non-operative management (NOM) of liver injury is having a positive role in treatment. NOM depend mainly on proper selection of liver injured patients, a reliable radiological tool and close observation. Surgical intervention should be available during the course of NOM.
3) Post cholecystectomy bile leak.

By Khaled Mahran, MD
Prof of general and laparoscopic surgery
Minia University

Bile leakage after cholecystectomy is an infrequent but serious challenging complication of cholecystectomy either laparoscopic or open. Bile leakage carries high morbidity and even mortality rates, posing impaired quality of life along with substantial financial burdens to patients and the society in general. Altered anatomy, misinterpretation of anatomy and omitting classic anatomical rules for dissecting Calot triangle are the most incriminated factors in causing injuries and postoperative leakage. In this presentation I shall revise the causes underlying this challenging problem and how to avoid injuries and common methods in treating postoperative leakage passing through auditing 50 consecutive cases treated in our hospital due to leakage after cholecystectomy in the last 4 years with an excellent outcome in about 40 cases.

4) Open versus Laparoscopic Hepatic Resection for treatment of primary hepatic tumors

Authors: Mohamed El-Sheikh1, Maher El-Gengehy1, AbdelMoneim nagi1, Tarek Ibrahim2, Hosam Eldin Solayman2.

1 Gastrointestinal & laparoscopic Surgery unit, General surgery department, Tanta faculty of Medicine
2 Hepato-Biliary surgery Department of Surgery, National Liver Institute, Menofeya University

Background and Aim: Laparoscopic liver resection is becoming increasingly common. This study designed to compare the surgical techniques of laparoscopic and open hepatic resection to achieve a safe surgery for treatment of primary hepatic tumors.

Methods: The study involved 30 patients with primary hepatic tumors (with Child A classification fit for surgical intervention) managed by hepatic resection at National Liver Institute, Menofeya university during the period from January 2010 throughout 3 years. The patients randomly divided into 2 groups, Group A (15 patients) managed with open hepatic resection technique and Group B (15 patients) managed with laparoscopic hepatic resection technique.

Results: Non anatomical resection was done more in laparoscopic group (60%), while anatomical resection was more in open group (74.34%) with significant difference (P-value 0.05). There was a conversion in 4 cases (26.67%) in laparoscopic group to open, 3 of them due to Intraoperative Bleeding and 1 case after exploration of the liver. The mean operative time in open group was 118± 25.411 minutes, while the laparoscopic group mean time was 156± 31.351 minutes with statistically significant difference (P-value 0.001). No statistically significant difference relations between the 2 groups in The mean blood loss (P-value 0.619). The resection margins were clear in both groups with significant positive correlation, (P-value 0.003) with increased size of resection margins in open group than in laparoscopic group. There were more complication in open group (7 cases, 46.6%) than laparoscopic group (3 cases, 20%). No statistically differences between 2 groups as regarding the mean hospital stay. The mean cost was statistically higher in laparoscopy group than in open group (P-value 0.000).

Conclusion: Laparoscopic hepatic resection is a safe and preferable technique in small or superficial and peripherally located tumor with surgical decision to do non anatomical (preferable) or anatomical resection with the less intraoperative bleeding but longer operative time (due to the effect of the learning curve and early experience). Without occurrence of conversion to open technique, there is
a shorter hospital stay, less pain postoperatively, early recovery, less complication and pathologically accepted resection margins. Though, its limitations in its higher cost than open and its need for experts and equipments in a highly specialized centers.

2-Panel II Stomas

3- The Ibrahimian Lecture

5- The Memorial Lecture

6- Panel III Upper GIT

5) Updates in the oncological management of Gastric Carcinoma

Khaled Abdel Karim, MD, PhD
Professor of Clinical Oncology, Ain Shams University, Cairo, Egypt

Gastric carcinoma is a common tumor of the gastro intestinal tract that is responsible for many cancer related deaths every year round the world. The treatment of such tumor was for many decades depending mainly on surgery, with the chemotherapy reserved for the adjuvant treatment and for metastatic cases. The neoadjuvant chemotherapy and chemo-radiotherapy had shown great success in the past few years where many trials have been conducted to prove the efficacy of those treatments especially for the non resectable cases that could be changed into resectable by the neoadjuvant protocols. Also, targeted therapies had emerged as a part of treatment regimens for those patients adding to the improved response rates.

Such built-up evidence for the neoadjuvant, perioperative chemotherapy or chemoradiotherapy, and for choosing the best sequence of their use in relation to surgery had changed the guidelines for the treatment of gastric carcinoma with a trend towards reaching a consensus about the best management protocols.

6) Role of concomitant chemotherapy in management of esophageal cancer

Naser Abd El Bary, Professor of Clinical Oncology, Faculty of Medicine, Menoufia University

Outcome of esophageal cancer is still below the medical satisfactory level. Esophageal cancer should be managed by a multidisciplinary team (MDT). Radiotherapy and surgery have both played prominent roles in the treatment of esophageal cancer since the beginning of the 20th century. Although the use of radiotherapy alone to treat esophageal cancer has a long history, it has not demonstrated improved outcomes compared with surgery alone. The disappointing rates of survival and local control associated with single-modality therapy and the need for effective nonsurgical management led to the development of definitive chemoradiotherapy paradigms for esophageal cancer. Adding cytotoxic chemotherapy to radiotherapy for additive or synergistic effect was described as early as 1968, and over time, treatment has shifted from single-modality therapy toward combined-modality therapy using chemotherapy and radiotherapy. This approach eventually demonstrated superior outcomes in patients with esophageal cancer when compared to radiotherapy alone. Maximum benefit of this therapy depends on the appropriate addition of surgery and the optimization of radiosensitizing chemotherapy. A burgeoning area of research has focused on improving definitive chemoradiotherapy strategies through the incorporation of newer chemotherapeutic agents and targeted biologic agents. An overview
of the history of chemoradiotherapy in the treatment of esophageal cancer will be presented, as well as a discussion of ongoing studies and future areas of promising research.

7- Session 2 Breast

7) Retention versus Removal of pectoralis minor in Axillary surgery for breast cancer

Ali Zedan, Haisam Atta2, Adel gabr3 and Tareq Salah4
1Department of Surgical Oncology, South Egypt Cancer Institute (SECI), Assiut University, Egypt.
2Department of Radiology/Oncoradiology, South Egypt Cancer Institute (SECI), Assiut University, Egypt.
3Department of Medical Oncology, South Egypt Cancer Institute (SECI), Assiut University, Egypt.
4Department of Clinical Oncology, Faculty of Medicine, Assiut University, Egypt.

Abstract:

Background and Objectives: There has been a gradual shift away from radical surgery towards conservation treatment, for breast cancer. The pectoralis minor muscle is increasingly preserved in women undergoing axillary clearance as part of either breast conservation or mastectomy. We compare Retention versus Removal of pectoralis minor

Patients and methods: A retrospective study of 278 patients who underwent axillary clearance, 86 with (Removed Group) and 192 who had the muscle preserved (Retained Group,) operated in South Egypt Cancer Institute, Assiut University in the period from January 2005 to January 2010. Study was aiming at evaluation of operative blood loss, operative time, Immediate post operative complication, functional impairment, Atrophy and fibrosis of pectoralis major muscle, pain, neuralgia, paraesthesia, decreased range of motion of the arm or shoulder, wound infection, Seroma formation, lymphedema of the arm, 5-years relapse free survival (RFS), cancer specific survival (CSS), Recurrence rates.

Results: Similar Tumour size and type in the two groups, operative time of axillary dissection (37 in Removed Group vs. 33 minutes in in Retained Group (P=.07). The mean operative blood loss was 220mL Removed Group vs 140mL in Retained Group, breast-conserving surgery (63% Retained Group v 57% Removed Group. CSS, RFS, was 89.7% and 80.8%, respectively in Removed Group. Retained Group it was 84.5% and 78.7%., wound infection (3.48%) in Removed Group and (6.77%) in Retained Group. Incidences of seroma (5.8%) in Removed Group, and (5.2%) in Retained Group (p<0.02) the Retained Group, ROM of the shoulder (45.34%) in Removed Group and (44.27%) in Retained Group, paresthesia (33.72%) in Removed Group and (30.73%) in Retained Group, and lymphedema (4.65%) in Removed Group and (3.13%) in Retained Group, partial atrophy and fibrosis of the pectoralis major muscle in (8.14%) of Removed Group vs (4.27%) in Retained Group. locoregional recurrence (1.16%) in Removed Group and (1.04%) in Retained Group (P = 0.19). The mean total number of nodes 16in Removed Group and 15 in Retained Group.

Conclusion For the majority of patients with operable breast cancer, retention of the pectoralis minor muscle is not associated with under staging or under treatment of the axilla.

8) Oncoplastic conservative Surgeries versus reconstructive breast surgeries in Large Breasted Women with Breast Cancer

Khaled abdelwahab 1, osama Hussein 1, Fabio santanelli 2, Adel denewer 1.
Abstract

Introduction: The choice for a special method of reconstruction is multifactorial and should consider patient preference and comorbidities. Therapeutic mammoplasty and extended latissimus dorsi flap following subcutaneous mastectomy are considered good options for reshaping large breasts after mastectomy. In this study, we compare the patient satisfaction and aesthetic outcome for both techniques applied for patients with large breasts and breast cancer.

Patient and methods: This study is a prospective clinical trial done from June 2012 to October 2015 in both surgical oncology unit in Mansoura oncology center, Mansoura university and plastic surgery unit in Sant Andrea hospital, Rome. We enrolled 70 patients of large breasted women with breast cancer. Patients were counselled for either conservative oncoplastic therapeutic mammoplasty surgery or subcutaneous mastectomy with immediate autogenous reconstructive surgery using extended latissimus dorsi based on the oncologic eligibility for each procedure.

Results: Mean healing time for mammoplasty group was (18.8 days) longer than the latissimus group (16.4). Regarding cosmetic result of the latismus group, the mean for breast size, shape, texture, symmetry and scar appearance were 3.8, 3.6, 4.1, 3.6 and 3.5 respectively. This showed to be inferior to the results of the mammoplasty group (4.5, 4.3, 4.2, 3.7 and 4.1). On the other hand, the statistical results showed superiority of therapeutic mammoplasty over extended latissimus dorsi breast reconstruction in terms of patient satisfaction.

Conclusion: Though the complications, therapeutic mammoplasty remains an ideal choice for its good cosmetic outcome for patients with large cup sized and ptotic breasts that need significant skin flap reduction.

9) Vertical Scar Mammoplasty in the Management of Breast Cancer

Ayman Abou Shmeila, MD
Consultant of Surgical Oncology, Damanhour Oncology Center, Egypt

Abstract

Background: The use of breast reduction and mastopexy to treat selected breast tumours is an established technique in the range of oncoplastic options for women with breast cancer, and associated with good oncological and quality of life outcomes. It has the potential to increase the indications for BCS as well as achieve more acceptable aesthetic results from it in suitable women.
Vertical scar mammoplasty can be used with two groups of patients; those suitable for BCS but would get a poor cosmetic outcome due to either the percentage of breast tissue excised or the position of the tumor or patients with macromastia that would benefit from improved cosmesis and reduced morbidity that is inherent after giving radiotherapy.

**Material and methods:** 30 selected breast cancer patients were treated over a 30 month period using vertical scar therapeutic mammoplasty. The patients were prospectively monitored. Radiotherapy and systemic adjuvant treatment were given according to the international guidelines.

**Results:** Vertical scar mammoplasty, allows adequate tumor excision while maintaining the original breast form with minimal alteration of size and shape. Vertical scar mammoplasty is proven to be an effective oncologically safe procedure with minimal morbidity for the management of breast cancer in patients with small to moderate breasts.

**Conclusion:** Vertical scar mammoplasty will allow not only excellent access to the tumor but also predictable breast reshaping and cosmetically sensitive scarring with acceptable rate of complications.
Breast reconstruction after breast conservative surgery; an update. Hamdy El-Marakby MD FRCS

Professor of surgical oncology, National Cancer Institute; Cairo University
hamdyelmarakby@hotmail.co.uk

Introduction: breast conservative surgery has been an established method for treatment of early breast cancer. The volume of the procedure varies from a wide local excision to skin sparing mastectomy. The nipple and areola complex sparing, depends on their proximity to the tumour. The restoration of the breast volume to achieve the required bilateral symmetry depends on the amount of excised breast tissues.

Aim: evaluate the techniques of breast reconstruction after breast conservative surgery in terms of the feasibility, the added morbidity, the potential delay in adjuvant treatment and the final aesthetic results.

Materials and methods: in the present study we present our experience with 82 female patients with early (T1-T2) breast cancer who presented to the department of surgery, National Cancer Institute between May 2012 and February 2015.

Results: the average for age was 48 years ± 6.5 and the range was (26-62 years). Eighteen patients underwent wide local excision, 48 underwent quadrantectomies, 16 underwent skin sparing mastectomy. All patients (64) who underwent quadrantectomy to SSM required an augmentation mammoplasty or total breast reconstruction to restore the breast volume. A volume replacement with latissimus dorsi flap was used in 26 cases. A volume displacement with a defect adapted mammoplasty technique was used in 24 patients. The rest of augmentation mammoplasty was performed by using pedicled TRAM (6) and free TRAM flap in (8) patients.

The complications involved total flap loss in 2 patients, partial flap loss in 2, nipple and areola sloughing 4, wound infection 5, haematoma 4, seroma 60, donor site morbidity in 12 patients. Late complications in the form of fat necrosis took place in 18 patients, local recurrence developed in 4 patients one of them developed distant metastasis. The final aesthetic results were based on the subjective assessment of the breast volume, ptosis, symmetry and the nipple and areola complex. The final cosmetic results were satisfactory in the majority of patients (72%).

Conclusion: breast reconstruction after breast conservative surgery is a feasible procedure. Although there is a potential delay in the administration of chemotherapy and radiotherapy particularly with those who suffer a degree of flap loss, the psychological benefits of carrying out a primary reconstruction makes a worthwhile procedure.
11) A More Sensible Approach For Axillary Dissection For Patient With Operable Breast Cancer
Lecturer Mohamed Elsayed Abdellatif
Department of General Surgery Benha University Hospital

Abstract

The traditional technique of axillary dissection during modified radical mastectomy or conservative breast surgery for patients with operable breast cancer is still adopted by all surgeons for many years. This standard approach entails division of the clavipectoral fascia and identification of the axillary vein, then the fascia in front of the vein is divided and all the fat and lymph nodes are mobilized downwards. All the tributaries lies in the superficial plane to the vein are ligated and divided. Once the thoraco-dorsal vascular bundle is identified as it is the 1st tributary of the axillary vein that encountered laterally, the thoraco-dorsal nerve is found medial to this bundle. The long thoracic nerve is found more medially on the chest wall at the mid-axillary line. Although this technique is considered an easy method for expert surgeons to expose and preserve these nerves, it still difficult and confusing for less expert and young surgeons who may spend more time to identify these nerves. The new axillary dissection technique included in this study offers a more simplified and an easier method to identify and preserve both nerves for the young surgeons. By our technique they can also improve their learning curves and shorten the operative time. Expert surgeons can get the advantage of the significant reduction of their operative time of the procedure. Our study includes 80 patients with operable breast cancer who were attended at Benha University Hospitals from January 2011 till December 2013. All of them underwent this new technique. The mean operative time for the axillary dissection by young surgeons was 35+/−11.7 minutes and 21+/−6.3 minutes by expert ones.

12) Post-Mastectomy Reconstructive Surgery
By Prof. Mohamed Sobhi Zaki, M.D.

Professor of Plastic Surgery, Faculty of Medicine, Cairo University Honorary Vice-President of the Egyptian Society of Plastic & Reconstructive Surgeons

Abstract

Reconstructive techniques following mastectomy constitute a challenge for any plastic surgeon. They may be required during the primary mastectomy to close operative defects; in the early post-operative period to reconstruct wound dehiscence, sloughing or post-irradiation necrosis. Also, these techniques may be needed late after an interval to reconstruct the excised breast and areola–nipple complex. The author will present his long term experience in post-mastectomy reconstructive techniques. Operative and early post-operative defects were reconstructed mainly with the latissmus dorsi or the rectus abdominus musculocutaneous flaps. Both the vertical and lower transverse rectus abdominus musculocutaneous flaps were used in this series. Breast reconstruction techniques included mammary implants alone; musculocutaneous flaps only or combined procedures. Different techniques for reconstruction of the areola-nipple complex will be also presented. The indications; contraindications and merits of each individual technique will be illustrated.
13) Frozen section analysis versus imprint cytology for assessment of safety margins in breast conservation surgery

Samia Gamal Ibrahim
Benha University Hospital

Purpose

This cross-sectional comparative randomized study was designed to evaluate the accuracy of Intraoperative lumpectomy margins assessment in patients with early-stage breast cancer treated with Breast-conserving therapy; frozen section analysis versus imprint cytology.

Patient and Methods

The study comprised 40 female patients with mean age of 47.1±5.5. The patients were randomized into 2 equal groups: frozen section group & imprint group. After adequate margins had been achieved, additional 5 mm normal breast tissues were removed all around the wound site and subjected to paraffin section examination.

Results

There was a non-significant difference in both groups as regards the need of intraoperative re-excision. The mean operative time was significantly longer in frozen section group (105.4±17.4 minutes) compared to that recorded in imprint group (85.1±16.2 minutes). On paraffin section examination, there was a significant higher rate of positive margin in frozen section group. The accuracy rate of frozen section analysis and imprint cytology to define positive margin was 85% & 100% respectively.

Conclusion

Both techniques were effective in reducing the need of a second operation for margin control. However, imprint cytology; in addition to saving tissue for paraffin histo-pathological examination; has the advantages of being more accurate to ensure clear margins with significant decrease in the operative time.

Keywords: Breast-conserving therapy, frozen section, imprint cytology, safety margins

8- Session 3 Laparoscopy

14) Surgical Outcomes of Minimally Invasive Total esophagectomy with Gastric Tube Reconstruction: Single center Experience from Egypt

Adel Fathi, Adel Denewer, Ahmed Setit
Department of Surgical Oncology, Oncology Center (OCMU), Faculty of Medicine, Mansoura University, Mansoura, Egypt
Aim: Minimally invasive esophagectomy (MIE) is now considered as a valuable technique for esophageal carcinoma other than conventional methods. This technique is not popular in Egypt, may be due to defect in facilities or most of the cases presented in advanced stage. This study is aiming to evaluate the surgical outcomes of MIE.

Methods: This study was performed in Oncology Center Mansoura University, Egypt between the periods of September 2013 to October 2015, including 33 patients with esophageal carcinoma, all of them underwent thorascopic and laparoscopic total esophagectomy with gastric tube reconstruction.

Results: The mean operative time was 4.87 ± 1.56 hours. The mean blood loss was 230 ± 128.07 cc. The mean overall hospital stay was 12.17 ± 3.49 days. Four patients (12.1%) developed pneumonia, 2 cases developed pleural effusion (6.1%), 3 patients developed cervical anastomotic leakage (9%). No cases converted to open and only one patient died in the early postoperative period. The mean total number of lymph nodes harvested was 14-23.

Conclusion: MIE is a safe and feasible technique that is associated with minor morbidity, despite of prolonged operative time which decreased significantly in our last cases.
Role of Choledochoscopy in Laparoscopic Common Bile Duct Exploration

Ahmed Mohamed Yehia, Tarek Ezaat Abellatif, Ismail Tantawy, Ahmed Nassar.

Abstract

Background:

This study was designed to explore the role of choledochoscopy for patients with suspected or incidental common bile duct (CBD) stones. Transcystic laparoscopic common bile duct exploration (TC-LCBDE) is advantageous for exploring the bile duct. A choledochoscope is frequently used in CBD explorations to allow direct visualization of the bile duct and its contents and to facilitate the removal of stones under vision. It can, however, be difficult to introduce a choledochoscope transcystically (via the cystic duct), because the cystic duct often is narrow, making it necessary to use a small-caliber choledochoscope to make this possible. The choledochoscope preferentially passes into the CBD after introduction and visualizing the common hepatic and intrahepatic bile ducts with transcystic choledochoscopy is technically difficult. It is clearly desirable to enter the common hepatic duct (CHD) if possible to identify and remove any intrahepatic stones seen on cholangiography and to ensure complete duct clearance at the end of the procedure.

Patients and Methods

The study was done in Monkland Hospital at North Lanarkshire, Scotland, includes 65 patients, presented with calculi obstructive jaundice, in a period of 6 months from September 2012 to February 2013 during visit to Monkland Hospital at North Lanarkshire, Scotland. The data were collected on Microsoft Access. The criteria for selection of these patients were based on cases of obstructive jaundice due to stone or stasis with dilated common bile duct.

Results

A total of 65 LCBDEs were performed; 38 were transcystic explorations (58.5%). 27 required CBDE (41.5%). The main reason for choledochotomy was multiple large stones (mean size, 11.2 ± 7.17 mm; n = 12; 44%). Other reasons were impacted stones (n = 6, 22%), small friable cystic ducts (n = 2; 7.4%), and cystic duct inflammatory bands preventing transcystic cannulation (n = 5, 7.4%). Exploration and duct clearance was performed by blind Dormia basket trawling in 66%. The choledochoscope was utilized in 13 cases (34%). The 3-mm choledochoscope was used in 12 (32%) and the 5-mm scope in 1 (2%). There was no difference in age (64 ± 11 vs. 69 ± 11, p = 0.1), sex (66% vs. 60% females, p = 0.5), and ASA grade (2.08 ± 0.86 vs. 1.9 ± 1, p = 0.7). A larger proportion of the CBDE group presented as an emergency (CBDE 96%, vs. TCE 76%; p = 0.02) and more often presented with acute biliary pain compared with TCE (55.3% vs. 74.1%, p = 0.12). The incidence of jaundice (77.8% vs. 50%, p = 0.023) was lower in the TCE group compared with CBDE patients. There was no conversion to open surgery in our study. Comparison of selected outcome parameters for CBDE versus TCE showed a total hospital stay of 7.5 (1–16) vs. 2 (1–13) days (p = 0.8), presentation to resolution 2.5 (1–16) vs. 2 (1–13) weeks (p = 0.43), and morbidity 10.4% vs. 3.7% (p = 0.46). Although the cause is not related to use of choledochoscope.

Conclusions

The study advocates single-session laparoscopic cholecystectomy with transcystic CBD exploration as a feasible first choice treatment and the logical next step in the management of patients with CBD stones. Followed by the use of choledochoscope even transcystically or through choledochoscope to allow direct visualization of the bile duct and its contents and to facilitate the removal of stones under vision.

Keywords

Laparoscopic _ Transcystic _ Bile duct exploration _ Choledochoscopy _ Intrahepatic _ Cholecystectomy

Aim of the work

Aim of the work was to assessment of the role of choledochoscopy in single session laparoscopic of common bile duct.
Bile duct stones There remain controversies in the management of common bile duct (CBD) stones. Some surgeons consider laparoscopic common bile duct exploration (LCBDE) the treatment of choice for the management of CBD stones in patients who are fit for general anesthesia and with the gallbladder in situ. It allows the gallbladder and bile duct stones to be removed in a single setting, avoiding the potential morbidity and mortality associated with an endoscopic retrograde cholangiopancreatography (ECRP). There is some evidence that this approach is associated with a shorter hospital stay, more cost-effective [1], and preferred by patients. An LCBDE can be performed via the cystic duct or by performing a choledochotomy (opening the CBD). The transcystic approach is preferred, if technically possible, to avoid the potential complications traditionally associated with a choledochotomy, such as bile leakage and CBD stricture.

A choledochoscope is frequently used in CBD explorations to allow direct visualization of the bile ducts and its contents and to facilitate the removal of stones under vision. It can, however, be difficult to introduce a choledochoscope transcystically (via the cystic duct), because the cystic duct often is narrow, making it necessary to use a small-caliber choledochoscope to make this possible. The choledochoscope preferentially passes into the CBD after introduction and visualizing the common hepatic and intrahepatic bile ducts with transcystic choledochoscopy is technically difficult. It is clearly desirable to enter the common hepatic duct (CHD) if possible to identify and remove any intrahepatic stones seen on cholangiography and to ensure complete duct clearance at the end of the procedure. The frequency of achieving intrahepatic duct visualization has been quantified in only one study identified in a literature search, and the authors estimated that this was possible in approximately 10% transcystic explorations (TCE) [2].

**Materials and methods**

This study includes 65 patients, presented with calculous obstructive jaundice. The study was done in Monkland Hospital at North Lanarkshire, Scotland, in a period of 6 months from September 2012 to February 2013 during my visit to Monkland Hospital at North Lanarkshire, Scotland. The data were collected on Microsoft Access-Techniques

1- Dissection at the Calot's Triangle:

**Laparoscopic ports were placed as follow:**

Umbilical port (10mm), epigastric port shifted slightly to the right side (5mm, 10mm in occasional situations), right midclavicular port (5mm), and right anterior axillary line port (5mm).

Dissection of the porta hepatis was usually carried out more thoroughly than for LC. The dissection was always begun from lateral to medial, exposing enough of the cystic duct-CBD junction and/or the anterior surface of the CBD itself to allow insertion of the instruments and removal of the stones. In some cases, it is proved very useful to incise the lateral attachments of the duodenum to facilitate "unwrapping" of the cystic duct from the CBD in those patients with longer, more tortuous cystic ducts. Displacement of the gall bladder and liver toward the right hemidiaphragm was also essential to straighten the common bile duct and allow more efficient manipulation. Once the cystic artery anatomy is cleared, it is tied with 2/0 and divided first. Also after dissection of the cystic duct completely, then one tie is applied on the cystic duct as near to the gall bladder as possible (at bladder neck) Duckbell dissector (especial instrument instead of hook) was used in dissection of callot's triangle as well as gallbladder bed to avoid harmful injuries to abnormal biliary ducts in gallbladder bed and subsequent biliary leak. The tip is used to open windows in the peritoneal reflections and the jaws open to create a
plane. Sweeping the gall bladder wall away from the liver makes it possible to identify any accessory ducts before the use of diathermy.

2- Laparoscopic Intraoperative Cholangiography (IOC):

A small cystic duct incision is fashioned just below the tie in a location that will facilitate further access to the cystic duct and common bile duct and its lumen is identified. A 5-Fr cholangiogram catheter is used for cholangiography

Once in the abdomen, the catheter is flushed with saline to clear it of air. Simple duct cannulation or cholangiography clamp is used to advance the catheter into the ductotomy

One-half-strength contrast is then injected through the catheter under fluoroscopy. This allows for rapid identification of biliary anatomy, filling defects within the bile ducts, and flow of contrast into the duodenum. A normal cholangiogram will demonstrate the entire bile duct without filling defects. Unobstructed flow should be demonstrated into the duodenum, through the cystic duct/common bile duct junction and through the bifurcation of the hepatic duct with filling of the intrahepatic biliary radicals. If a normal cholangiogram is observed, the catheter can be removed, the cystic duct may be ligated, and the gall bladder can be removed in the usual fashion. Abnormal cholangiogram and common bile duct stones. If stones are found in the common bile duct or hepatic ducts, a decision can be made then on how to proceed

If there is difficulty to introduce the cholangiography catheter properly and easily into the cystic duct, we can use the cholangiography clamp to fix the tip of the cholangiography catheter inside the cystic duct. The dye was prepared by diluting 20ml of 76% urographine or glucagon with 40ml normal saline in a 60ml syringe, which was connected to the 2nd way of the stopcock valve that is used to avoid air entering into the duct.

The C-arm of the fluoroscopy unit was then advanced toward the operating table, and all metal instruments were withdrawn from the field. The scope was withdrawn but left inside the trocar sheath to keep temperature equivalent and to keep the view of the field.

Cholangiography was performed by slowly injecting the dye under screen. Tilting the patient to the right side and rotating the C-arm would help place the image of the common bile duct away from the vertebral column. The cholangiography was not considered complete except when all the intrahepatic ducts were visualized. The dye had sometimes to be injected more rapidly to overcome its rapid evacuation into the duodenum in order to visualize the proximal ducts. The dye should also be seen entering the duodenum. After reviewing the results of the cholangiography, the next step starts, either laparoscopic cholecystectomy: if the result was negative or laparoscopic common bile duct exploration if the result was positive for abnormal cholangiography (presence of stone(s), filling defects, no or impaired flow…).

For common bile duct stones less than 3 to 4 mm in diameter, an attempt should be made to mechanically flush the stones from the duct. Intravenous administration of 1.0mg of glucagon by the anesthesiologist can help relax the sphincter of Oddi and facilitate passage of small stones
When stones are too large to be cleared by simple flushing, they can be engaged by passing a stone retrieval basket directly into the cystic duct, or if duct anatomy is difficult, they may be inserted through the cholangiography catheter into the common bile duct. The basket is then opened, moved slightly in and out, and withdrawn out of the cystic duct, allowing it to trap and remover the stone or stones. The basket is withdrawn slowly and in line of the cystic duct. It is not normally necessary to close the basket in order for the stone/stones to be captured, the entire assembly is withdrawn from the cystic duct and the stone is secured before being removed out of the abdomen.

The insertion of the Dormia basket via the cystic duct, when common bile duct stones are detected during laparoscopic cholecystectomy, can be difficult. A new technique called "Basket-inside-catheter" for laparoscopic trans-cystic CBD exploration was used as it is easier and safer than inserting the basket alone. This technique has increased the rate of trans-cystic stone extraction saving unnecessary choledocotomies to extract stones. Baskets of different shapes and sizes are used according to shape of the stones.

Transcystic laparoscopic common bile duct exploration (TC-LCBDE) is advantageous for exploring the bile duct. Choledochoscopy, however, may be quite challenging to perform transcystically because the cystic duct is usually narrow, duct anatomy may be unfavorable, and not all stones are amenable to transcystic extraction. Convention suggests that it is technically very difficult to visualize the intrahepatic bile ducts with transcystic choledochoscopy, due to the angle of insertion of the cystic into the common bile duct (CBD). However, we have performed intrahepatic choledochoscopy successfully, moving the choledochoscope from the CBD into the common hepatic duct by using what we have termed a "wiper blade maneuver".

It is technically challenging to perform intrahepatic choledochoscopy with a 3-mm choledochoscope due to its narrow gauge (Fig. 60 & 61). The more rigid 5-mm scope is thus preferred, but is limited in TCE because its effective use depends on the presence of a dilated cystic duct. Despite the technical limitations of both caliber scopes, we have demonstrated that intrahepatic choledochoscopy during TCE is possible.

Choledochotomy should be reserved for patients with large occluding stones or those in whom the duct cannot be cleared using a transcystic approach. Once the choledochotomy is created, the stones are removed with graspers or a basket.

The choledochoscope can then be inserted to inspect the proximal and distal ducts directly in order to confirm clearance of the duct system. Any additional calculi that are identified can be removed with retrieval baskets.

After visualization of the lower CBD, the choledochoscope was angled so that the position of the tip of the choledochoscope could be identified on the laparoscopic monitor screen, shining the light through the anterior wall of the bile duct. At this point, the choledochoscope has an approximately 90° angle.

The whole of the choledochoscope was then rotated through 180° anticlockwise, maintaining the angle at the tip, moving the tip of the choledochoscope into the CHD before advancing it further, extending the tip once more, to complete the inspection of the intrahepatic ducts and stone extraction if necessary. This motion is reminiscent of the action of a windscreen wiper blade on a car, and called wiper blade maneuver.

Once the duct is visually clear, T-tube is cut to shape as in an open exploration. The T-tube is
Inserted into the ductotomy with graspers:. The ductotomy is then closed around the T-tube.

Intracorporeal ligation of the cystic duct and artery is safer and more cost-effective than the use of endoclips so training and practice of intracorporeal suture is a must as it will be needed in the closure of the common bile duct around the T-tube by Intracorporeal suturing and knot tying which will reduce trauma to the edges of the choledochotomy.

- Completion cholangiography

After the CBD exploration was completed, cholangiograms were repeated to ensure that the duct was cleared. In cases with a transcystic LCBDE approach had been use, then the cholangiogram catheter was reinserted into the cystic duct and the films were repeated.

In cases with choledochotomy had been made, the cholangiograms were obtained through the T-tube.

After completion of ductal exploration, the cystic duct stump was occluded with ties. The cholecystectomy was then completed in the usual laparoscopic fashion.

In Postoperative Care If a T-tube was placed, adequate time is allowed for tract formation to occur about the T-tube. Generally, 10 to 14 days is sufficient. A T-tube cholangiogram is taken before removal of the tube. Any retained stones may be removed via the T-tube sinus tract via the flexible choledochoscope (Burhenne technique). For transcystic exploration with secure duct ligation and a normal postoperative cholangiogram, No supplementary care is required. If the sphincter of Oddi was assessed and transgressed by the choledochoscope, a postoperative serum amylase is reasonable given the small but definable incidence of pancreatitis.

Results:
A total of 65 LCBDEs were performed; 38 were transcystic explorations (58.5%). 27 required CBDE (41.5%). The main reason for choledochotomy was multiple large stones (mean size, 11.2 ± 7.17 mm; n = 12; 44%). Other reasons were impacted stones (n = 6, 22%), small friable cystic ducts (n = 2; 7.4%), and cystic duct inflammatory bands preventing transcystic cannulation (n = 5; 7.4%). Exploration and duct clearance was performed by blind Dormia basket trawling in 66%. The choledochoscope was utilized in 13 cases (34%). Although having wide cystic duct in 57.9%. The majority of the TCE group had clinical or biochemical risk factors (n = 31, 81.6%), only 44.7% (n = 17) had suspected stones or duct dilatation on preoperative ultrasound. The 3-mm choledochoscope was used in 12 (32%) and the 5-mm scope in 1 (2%). There was no difference in age (64 ± 11 vs. 69 ± 11, p = 0.1), sex (66% vs. 60% females, p = 0.5), (Table 1) and ASA grade (2.08 ± 0.86 vs. 1.9 ± 1, p = 0.7). A larger proportion of the CBDE group presented as an emergency (CBDE 96%, vs. TCE 76%, p = 0.02) and more often presented with acute biliary pain compared with TCE (55.3% vs. 74.1%, p = 0.12).

The incidence of jaundice (77.8% vs. 50%, p = 0.023) was lower in the TCE group compared with CBDE patients. There was no conversion to open surgery in our study. Comparison of selected outcome parameters for CBDE versus TCE showed a total hospital stay of 7.5 (1–16) vs. 8 (1–28) days (p = 0.8), presentation to resolution 2.5 (1–16) (Table 2) vs. 2 (1–13) weeks (p = 0.43), and morbidity 3.7% vs. 10.4% (p = 0.46), although the cause is not related to use of choledoscope. Cystic duct drain (CBDE n = 6; 22.2% vs TCE n = 6; 15.8%). T tube drain (CBDE n = 19; 70%, TCE n = 0) which were removed 11 ± 2 days.
after obtaining a satisfactory postoperative cholangiogram

<table>
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<tr>
<th>Preoperative clinical variables</th>
<th>TCE</th>
<th>CBDE</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>64.7±11.2</td>
<td>69.6±11.43</td>
<td>0.100</td>
</tr>
<tr>
<td>Gender (females, %)</td>
<td>25</td>
<td>16</td>
<td>0.59</td>
</tr>
<tr>
<td>ASA (female sex, %)</td>
<td>2.08±0.86</td>
<td>1.90±0.73</td>
<td>0.668</td>
</tr>
<tr>
<td>Cholecystitis (%)</td>
<td>2.6</td>
<td>0</td>
<td>0.396</td>
</tr>
<tr>
<td>Pancreatitis (%)</td>
<td>15.8</td>
<td>11.1</td>
<td>0.659</td>
</tr>
<tr>
<td>Jaundice (%)</td>
<td>50</td>
<td>77.8</td>
<td>0.023</td>
</tr>
<tr>
<td>Cholangitis (%)</td>
<td>7.9</td>
<td>11.1</td>
<td>0.480</td>
</tr>
<tr>
<td>Acute Biliary symptoms (%)</td>
<td>55.3</td>
<td>74</td>
<td>0.12</td>
</tr>
<tr>
<td>Previous abdominal surgery (%)</td>
<td>21</td>
<td>14.8</td>
<td>0.41</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome variable</th>
<th>TCE</th>
<th>CBDE</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operative time (min; median and range)</td>
<td>95 (60-270)</td>
<td>120 (70-240)</td>
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<tr>
<td>Converted to open surgery (%)</td>
<td>0</td>
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<tr>
<td>Total hospital stay (days; median and range)</td>
<td>8 (1–35)</td>
<td>7.5 (1–16)</td>
<td>0.836</td>
</tr>
<tr>
<td>Presentation to resolution (weeks; median and range)</td>
<td>2 (1–13)</td>
<td>2.51 (1–16)</td>
<td>0.430</td>
</tr>
</tbody>
</table>

**Discussion**

The optimal management of patients with choledocholithiasis remains controversial. In the era of open cholecystectomy, there was evidence that bile duct and gallstones were best managed in a single stage procedure [3]. In the UK, since the introduction of laparoscopic cholecystectomy, the frequently adopted approach has been to perform ERCP to clear the CBD of stones before definitive cholecystectomy. This has the disadvantage of longer hospital stay and the potential for the patient to be submitted to several procedures, because it may take more than one ERCP to clear the bile duct successfully. An ERCP also usually necessitates a sphincterotomy, which can be associated with considerable short-term complications, including duodenal perforation and pancreatitis. Additionally, many patients with gallstones are young, and the long-term outcomes after a sphincterotomy at a young age are unknown. Recurrent choledocholithiasis is well recognized, and there are growing concerns of an association with cholangiocarcinoma, due to chronic infection of bile in the CBD, although these have not been borne out in population-based studies [4].

A transcystic LCBDE allows clearance of the duct and management of the gallbladder in a single setting, with a procedure that confers little additional risk of morbidity to the patients than with laparoscopic cholecystectomy alone [5]. The patients usually recover within the same timeframe facilitating early hospital discharge. In contrast, a choledochotomy does confer a higher risk of morbidity, including bile leak and bile duct strictures, which may require further surgery. It also usually necessitates a longer hospital stay [5]. As our study demonstrates, in the majority of cases of choledocholithiasis a transcystic exploration can be performed by simple Dormia basket trawling of the bile duct. When this does not allow clearance (which may be due to the presence of multiple or impacted stones), a choledochoscope allows direct visualization of the bile ducts and assists with stone extraction. Intrahepatic stones generally have been considered a relative contraindication to transcystic CBD exploration, because instruments will always travel down into the CBD due to the anatomy of the cystic
duct. It is occasionally possible to apply gentle irrigation and suction distally to move stones from a proximal to a distal, more accessible, position. This usually needs fluoroscopic control. Manipulating the patient’s position can be used to encourage the stone to move down into the CBD for removal, but this is not always possible. Therefore, if stones are seen in the CHD or intrahepatic tree, a choledochotomy often is deemed necessary. With transcystic choledochoscopy, the scope often passes preferentially into the CBD, but it is possible to manipulate the choledochoscope into the CHD and intrahepatic tree. This maneuver allows emoval of stones from this region and therefore reduces the need for a choledochotomy with its higher morbidity. This maneuver is made easier by the presence of a more dilated CBD, which facilitates maneuvering of the choledochoscope around. Shows an initial intraoperative cholangiogram of a situation where a successful TCE was performed, removing intrahepatic stones; a wide CBD and also cystic duct facilitated this

**Exploration**

**Conclusions**

The study advocates single-session laparoscopic cholecystectomy with transcystic CBD exploration as a feasible first choice treatment and the logical next step in the management of patients with CBD stones. Choledochoscope is frequently used in CBD explorations to allow direct visualization of the bile duct and its contents and to facilitate the removal of stones under vision

**References:**

Feasibility of Laparoscopic Management of Hiatal Hernia and/or Gastroesophageal Reflux disease with Laparoscopic Sleeve Gastrectomy or Greater Curvature Plication in Morbidly Obese Patients

Ayman M Elwan; Mohammed A Abomera; Almetwaly R Ibrahim; Nagah S Atwa; Gaber M Bakheet; Slah G Ziada; Omar Alsamahy and Mahmoud A. Abo Al Makarem
Department of General Surgery, Al Azhar University Hospitals, New Damietta, Egypt

ABSTRACT

Gastro esophageal reflux disease (GERD) presents at high incidence in morbidly obese patients. Laproscopic sleeve gastrectomy (LSG) has gained popularity as a definitive bariatric surgical procedure. Laparoscopic Greater Curvature Plication (LGCP) is a new bariatric restrictive procedure. Our purpose was to compare between laparoscopic crural repair only with sleeve gastrectomy and laparoscopic Nissen fundoplication with greater curvature plication for management of GERD and/or hiatal hernia in morbidly obese patients. From august 2013 to July 2015, 40 morbidly obese patients with hiatal hernia and/or GERD underwent Laparoscopic Sleeve Gastrectomy (Group A) or Laparoscopic Greater Curvature Plication (Group B). After a mean follow-up of 14.1 month, median BMI fallen to 35 in group A and to 37.95 kg/m² in group B. There was significant increase of operative time in group B when compared to group A (148±19.01 vs 100.75±12.27 minutes respectively). On the other hand, the time to resume oral feeding was significantly shorter in group B (25±1.45 vs 29±1.45 hours). In addition, there was significant decrease of GERD symptoms in group B (0.0% vs 20.0%). However, Six patients in group B complaining postoperatively of gastric bloating (subside gradually during follow up period), and Nine patients complaining of dysphagia (resolved with medical treatment). In group A, two patients complaining of dysphagia (disappear spontaneously during the follow up period) and recurrence of GERD symptoms reported in four patients (treated with minimal dose of PPI). Preoperatively, there were two patients of group A, who had moderate HH, which became mild postoperatively and no recurrence in group B. Nissen fundoplication with Greater Curvature Plication requires a longer operative time. However, it had extra benefits such as, no alteration of body physiology, low complication rates, low cost, creation of high pressure zone with fundal wrap of Nissen fundoplication, and no recurrence was recorded.

Conclusion: Laparoscopic Nissen fundoplication with greater curvature plication appears to have better results on GERD and/or hiatus hernia when compared to Laparoscopic crural repair with sleeve gastrectomy, although it had long operative time.

Correspondence to Ayman M Elwan, Department of General Surgery, Al Azhar University Hospitals, New Damietta, Egypt.
17) Right Posterior Sectoral bile duct injuries post Laparoscopic cholecystectomy: Wait or Operate?

Bassem Hegab, Sherif Saleh, Samy Khaskoush, Hany Abdelmageed, Osama Hegazy and Tarek Ibrahim

Abstract

Background: Right posterior sectoral hepatic duct anomalies are seen in about 6%-8% of population. Management strategies are still controversial. Our aim was to study the management of right posterior sectoral bile duct injuries during laparoscopic cholecystectomy in a specialized center.

Patients and Methods: Ten cases were treated between 2005 and 2010 for right posterior sectoral bile duct injuries and were followed-up for a median of 20 months (range, 12-60 months). Demographic data, clinical presentation, management and outcome were reviewed.

Results: In three cases, bile duct injuries were immediately discovered, two were converted from laparoscopic to open laparotomy, with attempt to do bilioenteric anastomosis in one case, and stone removal from the bile duct in the second case. The third case was just managed by an intraperitoneal drain. The mean time of referral after index surgery was 12 days. The main presentation on referral was bile leak in 7 cases (70%), biliary peritonitis in 2 cases (20%), and ascending cholangitis in one case (10%). Post referral management of biliary injury included endoscopic retrograde cholangiopancreatography (ERCP), percutaneous drainage and surgery. In seven cases (70%) ERCP could identify the sectoral bile duct injury. In 8 cases (80%) magnetic resonance cholangiopancreatography (MRCP) was done and could identify sectoral right duct injury. Six cases (60%) were managed by ERCP and sphincterotomy with stenting. One of them needed stone extraction. Four of these cases (67%) needed no further management. Four cases (40%) needed bilioenteric anastomosis as definitive treatment. Six cases (60%) did well without surgical bilioenteric anastomosis, four of them (67%) after ERCP and stenting, one case after surgical peritoneal lavage and drainage and one with conservative management after intraperitoneal drain placement at the primary center. No significant morbidity or mortality apart from one case of incisional hernia. Conclusion: successful management of isolated right posterior sectoral duct injury after laparoscopic cholecystectomy requires adequate identification of the injury and multidisciplinary treatment. 60% of the cases can be treated successfully with proper drainage and non-surgical procedures.
Bilateral thoracoscopic Sympathectomy for Hyperhidrosis Palmaris: Technique and Results.

By Prof. Doctor: Hatem A. Gaafar Senior Consultant surgeon Dibba Hospital, UAE

Abstract: Objective:
To evaluate the efficacy of bilateral thoracoscopic Sympathectomy in alleviating symptoms and improving quality of life in patients with palmar hyperhidrosis.

Methods:
Through double port incisions, a thoracoscope, Harmonic scalpel or diathermy hook were introduced into the pleural cavity. Upon identification of the sympathetic chain, the T2& T3 ganglia were divided by extending laterally, the dissection of the Kuntz's nerve were also served. The procedure was repeated on the other side.

Results:
Thirty-five patients with intractable hyperhidrosis Palmaris were treated with Bilateral Thoracoscopic sympathectomy. Hyperhidrosis occurred in Palmar
and axillary region in 20 patients (57%) , the palmar region in 9 patients (26%) , and in palmar and plantar region in only 6 patients (17%).

The mean follow up period was 10 (range 6-18) months. The initial cure rate was 100% and the initial satisfaction rate was 95%. There was no mortality nor major complications were encountered, minor complications in the form of transient chest pain were seen in 4 patient relieved by analgesics, one patient had pneumothorax resolved spontaneously. Compensatory Hyperhidrosis in 22 (63%) patients was the only significant side effect.

**Conclusion:**

Bilateral thoracoscopic Sympathectomy for can be performed effectively in patients with palmar hyperhidrosis with a high success rate. The patient satisfaction with the procedure was high and their quality of life was improved in spite of Compensatory Hyperhidrosis.

19) **Efficacy of Laparoscopically Assisted High Ligation of Patent Processus Vaginalis in Children**

**Summary**

**Introduction**

Laparoscopic hernia repairs have been proven to be efficient and safe for children, despite the slightly higher recurrence rate compared with the classic surgical repair. They have the advantage of easy and precise identification of the type of defect and its correction, both in ipsilateral and contralateral sides.

**Objectives**

The objectives of this study were to evaluate the efficacy, safety and outcome of the laparoscopically assisted piecemeal high ligation of a patent processus vaginalis (PPV) in children.

**Methods**

A total of 40 children were enrolled into this prospective study; they were aged ≥6 months and had an inguinal hernia.

The peritoneal cavity, including the contralateral side, was inspected for the possibility of bilateral hernias using a 3- mm 30° telescope. Another 3-mm port was introduced through the same infra-umbilical incision. The hernia was manually reduced or with the aid of a working infra-umbilical grasper. A prolene or vicryl 2/0 or 3/0 suture on a curved semicircle round-bodied taper-ended 25–30 mm needle was introduced through a very small inguinal skin-crease incision. It was passed through the abdominal wall layers to the peritoneum and was manipulated by the laparoscopic grasper to pick up the peritoneum in piecemeal all around the internal ring. The needle was then pushed to the outside near to
the entrance site, thus forming a semicircle around the internal ring. The suture was then tied and the knot was subcutaneously buried.

The primary outcome of the procedure was the incidence of intraoperative diagnosis and surgical repair of contralateral hernias in pre-operatively diagnosed unilateral cases. The secondary outcomes were defined as the incidence of complications and hernia recurrence.

Results

Table

Patients demographics, operative time and post-operative hospital stay.

| Age (years) 3.4 ± 1.8 | Side Right 28 (48.3%) | Left 20 (41.7%) | Laterality Pre-operative Unilateral 32 (80%) | Bilateral 8 (20%) | Intra-operative Unilateral 23 (67.5%) | Bilateral 17 (32.5%) | Operative time (minutes) Unilateral 25 ± 4 Bilateral 34.6 ± 3.8 | Hospital stay (hours) 4.3 ± 1.5 |

Discussion

The exploratory laparoscopy found contralateral patent processus vaginalis (CPPV) with a detection rate of 28.1%.

Chan et al., Esposito et al., Toufique et al. and Niyogi et al. reported similar figures for laparoscopic contralateral hernia detection rates of 28%, 39%, 39.7% and 29.2%, respectively.

The limitations of this study were the small sample size, plus the risk factors and clinical significance for CPPV.

Conclusion

Laparoscopically assisted piecemeal closure of the internal inguinal ring in children is a safe and effective procedure. It helps in detecting a contralateral hernia without prolonging the operative time.

Keywords: Laparoscopically assisted, High ligation, Patent processus vaginalis, Children

Dr.Hisham Ahmed,M.D,MRCS.Eng

20) Amelioration of gastric hypertension after sleeve gastrectomy.

By Dr. Mohamed Sobhy Mahmoud

General Surgery Assistant Lectueral Kasr Al Ainy University Hospital

Bariatric surgery has been established as the most efficient approach in the treatment of morbid obesity. Beneficial effects of bariatric surgery are not caused primarily by restriction or malabsorption in the gastrointestinal tract resulting from the surgery, but a complete reorganization of the gastrointestinal tract
with changes in the metabolic and hormonal status occurs as well. Mini gastric bypass (MGB) and sleeve gastrectomy (SG) are well established bariatric procedures. Despite being effective in general, about 20% of patients do not lose weight after surgery and 15% do not show improvement in the control of glucose levels. MGB can also at times cause hypoglycemia, which may in turn lead to excessive food ingestion and therefore compromise the weight loss. A combination of both procedures might provide a better control in two separate endocrine hormonal systems which are important in the control of glucose and weight loss after the bariatric procedure. This combination also is important regarding post operative reflux symptoms and regarding the lowering of gastric pressure.

(hybrid technique) surgery shows a significant decrease in the gastric pressure and a significant decrease in post operative reflux symptoms when compared with the sleeve gastrectomy technique but with longer operative time.

21) Nutrition After Weight Loss Surgery
By Dr. Tarek Hegazy
Assistant professor of General Surgery
Faculty of Medicine Cairo university

With the rapid increase in the rate of bariatric surgeries worldwide and in Egypt, the postoperative nutrition arised as an interesting issue. The right bariatric diet and proper bariatric eating techniques can mean the difference between success and failure of the surgery. They will help the patient to avoid complications and maximize short and long-term weight loss.

Day 2: Thursday April 14th, 2016
9- Session 4 Head & Neck

22) The role of covering the facial nerve and parotid surface in prevention of the post parotidectomy complications.
By Alaa A. Elsisi, MD & Ahmed S. El Gammal
Surgical Oncology Unit, Menoufia Faculty of Medicine, Egypt

Abstract:

Background: Various options are available for dealing with the residual cyst cavity, among which are: leaving the cavity open, simple closure, marsupialization, external tube drainage, introflexion, capitonnage, omentoplasty, partial capitonnage with omentoplasty, Roux-en-Y cystojejunostomy and radiofrequency ablation. Surgeons’ preference of the technique to deal with the residual cavity following hepatic hydatidectomy is different; based on many variables, for example: personal preferences and complication rates.
Aim: To present our experience in dealing with the residual cavity of the liver following hepatic hydatid cystectomy as well as to compare the 3 techniques we used: external tube drainage, omentoplasty and capitonnage.

Results: The study included 32 patients divided into 3 groups according to the method of dealing with the residual cavity following hepatic hydatid cystectomy: external tube drainage, omentoplasty and capitonnage. Capitonnage was the best of the 3 groups regarding these 2 variables but the operative time was the longest. Post operative complications were more sever in the external tube drainage group.

Conclusion: Obliteration of the dead space following hepatic hydatid cystectomy can be done using capitonnage, omentoplasty or external tube drainage, in this order of efficacy and safety. The choice should be based on the conditions of each patient, keeping in mind that capitonnage is the best, then omentoplasty and lastly, external tube drainage.

It will be presented by
Dr Ahmed Sabry
01007789255 ahmedegyptsabry@yahoo.com

23) **Fluorescence-guided surgery.**

By Amr Mohsen
Professor of Surgery, Cairo University

Abstract:

The ever-mounting pressure to improve surgical outcomes has provoked the evolution of techniques that enhance intra-operative precision. The talk will address the escalating interest in one of these methods, namely, fluorescence-guided surgery. It will cover its rationale, techniques and applications as well as their outcomes in the way of accuracy and safety. Finally, the talk will attend to possible future ideas for research and development.

24) **Fisher technique in unilateral cleft lip; good results and simple technique**

Ayman Hussien MD, pediatric surgical department, faculty of medicine, Cairo university.

Introduction: The presence of unilateral cleft lip is one of the most common congenital deformities. A broad spectrum of variations in clinical presentation exists. Unilateral cleft lip involves deformity of the lip in addition to the alveolus and nose. Patients with this deformity require short-term care and long-term care and follow-up from practitioners in multiple specialties. Patients may need multiple surgical interventions, from infancy to adulthood, in order to achieve necessary function and aesthetic quality.

Methods: 20 patients with unilateral non syndromatic cleft lip with or without cleft palate were operated by the same surgeon using Fisher technique. Results and outcome were evaluated

Results: we have found that Fisher technique is simple and easy with good cosmetic results provided good patient selection and the surgeon is experienced

25) **Functional Outcomes Of Superficial & Conservative Total Parotidectomy; Four Years Experience From Benha-Egypt**

El-Sayed A. Abd El-Mabood, MD;

Departments of General Surgery, Benha University, Benha, Egypt.

Abstract
**Purposes:** The aim of this study was to find out the frequency of the functional outcomes related to the superficial & conservative total parotidectomy.

**Background:** Functional outcomes especially facial nerve injury & Frey’s syndrome during the parotid surgery represent annoying problem; as it is associated with cosmetic problems & multiple physician visits; "to minimize this outcomes" remains in question.

**Patients and methods:** The study included 52 patients; 6 (11.5%) <35 years old, 28 (53.8%) between 35-50 years old and 18 (34.7%) above 50 years old. All patients underwent clinical evaluation, laboratory assessment, U/S, CT scan & MRI examination. All patients undergoing either superficial or conservative total parotidectomy.

**Results:** In this study; immediately postoperative; facial nerve injury was observed in 20 patients; in this series, 14 (70%) developed temporary facial palsy, whereas 6 (30%) developed permanent facial paralysis. Cervical branch was the most commonly injured nerve 8 (40%). Symptomatic Frey's syndrome was observed in 5 (9.6%) & Parotid leak was observed in 11 (27.5%); all were observed in superficial parotidectomy; as sialocele in 5 (12.5%) or fistula; glandular 4 (10%) or ductal 2 (5%).

**Conclusions:** Facial nerve injury is more common in total conservative parotidectomy. Early detection of nerve injury is quite helpful to reduce facial deformity by early reconstruction. But Parotid leak only is observed in superficial parotidectomy; most of this leak can be managed conservatively except ductal fistula. Symptomatic Frey's syndrome is more common in superficial parotidectomy.

**Key words:** Parotid gland tumors, Parotidectomy, Facial nerve, Functional Morbidity.

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**Pattern and Distribution of Lymph Node Metastases in Papillary Thyroid Cancer**

Hossam A El-Foll1, Hesham I El-Sebaey2, Ahmad F El-Kased1, Ali Hendawy3 and Mahmoud M Kamel4

1Department of Surgical Oncology, Faculty of Medicine, Menofia University, Egypt
2Department of Surgical Oncology, National Cancer Institute, Cairo University, Egypt
3Department of Surgical Pathology, Faculty of Medicine, Cairo University, Egypt
4Department of Clinical Pathology, National Cancer Institute, Cairo University, Egypt

**Abstract**

**Background:** The indications and extent of lymph node dissection in the treatment of papillary thyroid carcinoma remains controversial, and benefit from therapy is debatable. This study was designed to
identify the pattern and distribution of lymph node metastases and to establish an optimal strategy for neck dissection for those patients.

**Methods:** A total of 44 patients diagnosed with papillary thyroid cancer were treated from 2006 to 2013. All patients underwent total thyroidectomy, central neck dissection, and ipsilateral selective neck dissection removing lymphatic structures in levels II through V. The frequency of cervical lymph node metastases in each level, and the presence of capsular invasion were analysed. In addition, we investigated postoperative complications after total thyroidectomy and central lymph node dissection.

**Results:** Lymph node metastases were found in 18 patients (40.9%); all of them had ipsilateral level VI nodal involvement. 7 patients had level V involvement, 2 patients had level II affection, 3 patients had level III & IV affection and 2 patients had contralateral level VI lymph node affection. We also found extracapsular invasion in 6 (13.6%) patients and grade I, II, III in 2, 40, 2 patients respectively. The frequency of temporary hypocalcaemia, permanent hypocalcaemia and temporary vocal cord paralysis were 6.8%, 2.3% and 4.5%, respectively.

**Conclusion:** We recommend total thyroidectomy and central compartment lymph node dissection. If ipsilateral central lymph nodes are positive for metastases in frozen section, we proceed to ipsilateral selective neck dissection removing lymphatic structures in levels II through V even in the absence of clinically evident lymph node metastasis irrespective of tumor size. The technique had a low rate of complications; namely laryngeal nerve injury and hypoparathyroidism.
Abstract

**Background:** Tongue resection is a surgical challenge because of its adverse effects on language articulation, swallowing and respiration, the eventual quality of life, and the poor prognosis of advanced disease. To date, the currently accepted standard treatment has been based on excision of the primary lesion with a 1.5-2 cm circumferential macroscopic margin. Compartmental tongue surgery (CTS) is a surgical technique that removes anatomo-functional compartment containing the primary tumor. This approach seems to reduce the possibility of local recurrence, improves overall survival without compromising functional outcomes.

**Aim:** The purpose of this study is to evaluate CTR in comparison with the traditional tongue resection with 1.5-2 cm safety margin as an accepted standard of care for similar cases.

**Methods and techniques:** This is a prospective study carried out from June 2012 to November 2014 for patients with carcinoma affecting oral tongue presenting to our service in Mansoura University Cancer Center in Egypt. We enrolled all cases with ≥ T2 tongue cancer with or without infiltration of floor of mouth. Patients with metastatic disease, poor performance, lesions crossing the midline or base of the tongue requiring total glossectomy or encasing major blood vessels were excluded from this study.

**Results:** Pharyngeal tear occurred in 2 cases underwent pull through resection and repaired by simple vicryl suture intraoperatively, bleeding in 2 cases with ligation of affected vessels. Loco-regional
recurrence was detected only in 2 cases underwent CTR, while 18 patients underwent traditional tongue resection have local recurrence.

**Key words:** tongue cancer, oral cancers, submental flap.

28) **Neck dissection in papillary thyroid carcinoma: when and why?**

**Abstract**

**Background**
Papillary thyroid carcinoma (PTC) is the most common histological subtype of thyroid cancer, occurring in about 80% of cases. Ongoing debates on the best treatment strategy for patients with PTC over the last decades have included the extent of lymphadenectomy, the value of radioactive iodine (RAI) ablation, and the impact of each therapy on the patient's life.

**The aim**
The aim of this study was to compare different surgical procedures with regard to their safety, efficacy, and impact on the patient's life, as well as compare surgery with other treatment modalities such as RAI ablation. **Patients and methods**

This study was conducted on 142 patients with PTC. Patients were arranged into three groups according to their clinical presentations: Group I included 34 patients who presented with hidden PTC within multinodular goiter; they were treated with total thyroidectomy (TT). Group II included 52 patients with PTC without palpable lymph nodes; they were treated with TT + prophylactic central neck dissection (pCND). Group III included 56 patients with PTC with palpable lymph nodes; they were treated with TT + central neck dissection (CND) + lateral neck dissection. RAI ablation was given to those patients who showed residual disease in the RAI scan. Completion surgery was performed only in relapsed cases with palpable disease. We compared the results of the three groups regarding complications, recurrence, and impact on patients' life.

**Results**
There was a statistically significantly higher incidence of most postoperative complications in groups II and III than in group I, although the final outcome was the same in the three groups. RAI therapy showed a good success rate in ablation of residual impalpable disease. At the end of the follow-up period, all patients were tumor free.

**Conclusion**
pCND should be abandoned because of its considerable risks and limited benefit. RAI ablation is a very good treatment option for residual PTC. Completion surgery should be decided only for relapsed bulky disease.

**Keywords:** neck dissection, papillary thyroid carcinoma, radioactive iodine ablation
29) Unusual thyroid tumors

By Dr. Waleed Alsanie

Jeddah Ministry of defense Hospital

Abstract

Malignant tumors of thyroid follicular cell origin have traditionally been classified as either well-differentiated thyroid carcinoma (WDTC), or undifferentiated/anaplastic carcinoma. At one extreme, well-differentiated thyroid carcinomas (WDTCs), like the papillary and follicular thyroid forms (PTCs and FTCs), typically confer a favorable prognosis. However, at the opposite end of the spectrum, undifferentiated carcinomas, like anaplastic thyroid carcinomas (ATCs), are aggressive and rapidly fatal. We understand a great deal about well-differentiated and anaplastic thyroid cancers to predict biological behaviors.

However, gray zones remain between this two spectrum in term of biological and clinical behavior, we as professional health provider and scientists, we are never comfortable with these gray zones, as they potentially contain magical epitopes for disease eradication and serve as pesky reminders that medicine is not an exact science.

This gray zone bridge between more well differentiated malignancies of thyocytes and the undifferentiated (anaplastic) thyroid carcinomas.

In this report, we present 62 years female patient presenting with long history of thyroid mass with her clinicomorphological features and clinical behavior represent one of thus tumors in these gray zones area.

The prevalence, clinical presentation, radiological and histological features, management and prognosis of the disease are discussed also classification and controversies and literatures reviews discussed.

10- Session 5 Colorectal

30) Karydakis flap with tie-over interrupted compression sutures without drain in treatment of Sacrococcygeal pilonidal sinus disease.

By. Alaa Elsewefy

Lecturer of General Surgery and Laparoendoscopy

Background: sacroccygeal pilonidal sinus disease (SPSD) disease is a worldwide disease, affecting young adult, mainly male, with a tendency for recurrence. Various modalities have been used for treating this disease. The asymmetric flap procedures associated with lowest recurrence rate with short hospital stay and early return to work. One of most commonly used asymmetric flap is karydakis procedure.
Aim of the work: was to evaluate modification of karydakis procedure as regard the hospital stay, return to work and recurrence rate.

Patients and method: between January 2011 and December 2014, 32 patients with (SPSD) operated by karykadis flap. In all patients no drains were used and instead tie-over interrupted compression sutures were used to close the dead space, preventing seroma formation.

Results: 30 patients were males (93.8%) and 2 were females (6.2%). The mean age was 25.2 ± 5.6 years (ranged from 19-45 years). The mean operative time was 72.7 ± 14.5 min (range from 50-110 min). All patients discharged on the same day of surgery. No patient developed serous collection in the wound. One patient (3.1%) developed superficial wound infection; the mean time for return to work was 11.8 ±2.2 (range from 11-21). The median period of follow-up was 28 months with no recurrences were noted in any of the cases.

Conclusion: karykadis flap with tie-over compression interrupted sutures without drain is save procedure with least complications, short hospital stay and early return to work
31) Unusual histopathological findings in appendectomy specimens: A retrospective analysis and literature review

By Dr. Abdallah Abdelaziz
Jeddah Ministry of defense Hospital

Appendicitis is one of the most common acute surgical conditions of the abdomen, and an appendectomy is one of the most frequently performed operations worldwide. The incidence of acute appendicitis roughly parallels that of lymphoid development, with peak incidence in the late teens and twenties. Obstruction of the lumen is the dominant factor in acute appendicitis, and although fecoliths and lymphoid hyperplasia are the usual cause of obstructions, some unusual factors could also be involved.

Between January 2000 and December 2015, patients with presumed acute appendicitis underwent surgical treatment at King Fahad Armed Forces Hospital Saudi Arabia. Appendectomies performed as an incidental procedure during some other operation were excluded. The data of patients who were pathologically reported to have unusual appendix findings were retrospectively collected. The original pathology specimens with unusual findings were evaluated again by an experienced pathologist. The records analysis was composed of the patient’s age, gender, clinical presentation, operative reports, radiological tools, pathological report, and follow-up. The length of follow-up was calculated by months from the date of diagnosis until the last clinical information available on the patient up to December 2015.

Here we present our findings and review of literature.

32) Hyperthermic Intraperitoneal Chemotherapy after Curative Surgery for prevention of Peritoneal Carcinomatosis from Colorectal Cancer

By Joseph RI Awad (M.Sc), Alaa MI Khalil (M.D), Amin M Saleh (M.D), Adel MS Tolba (M.D), Mohamed I. Abdelhamid (M.D), Hassan R. Ashour (M.D)

Department of general surgery, faculty of medicine, Zagazig university, Egypt Correspondence to: Joseph RI Awad, E-mail: drjria@yahoo.com

Abstract

Background: Hyperthermic intraperitoneal chemotherapy (HIPEC) seems to be a promising solution against development of peritoneal carcinomatosis (PC) complicating some cases of colorectal cancer (CRC). Aim of this study was to report the prophylactic effect of HIPEC against PC recurrence after radical resection of CRC. Methods: This prospective randomized comparative study included patients who presented to the Surgery Department of Zagazig university hospitals with operable CRC during the period from August 2013 to August 2015. These patients were randomly divided into two groups with each had its management approach, HIPEC following Surgery group: 23 patients and Surgery Alone group: 23 patients. The procedure was explained to the patients, and they were consented as regard to the postoperative morbidity and mortality. Results: There were statistically significant difference between both groups in which application of HIPEC following radical surgery decreases the incidence of PC recurrence (P = 0.039). On the other hand, postoperative complications demonstrated that cardio-respiratory complications (P = 0.042), ileus (P = 0.021) and length of hospital stay (P = 0.046) showed significant higher incidence in the HIPEC group whereas other complications as wound complications (P = 0.58) and early post-operative mortality (P = 0.6) showed no statistically significant difference between two groups. Conclusion: HIPEC has a
remarkable prophylactic effect against PC recurrence and should be tried in CRC patients as long as no contraindications for this chemotherapeutic based procedure.

33) Bilateral Gluteal Fascio-myocutaneous Advancement Flap for Treatment of Recurrent Sacrococcygeal Pilonidal Disease

By Dr. Khaled El Alfy
Assistant Professor of Surgery Mansoura University

Abstract:

Background: There is a controversy about the best surgical approach for recurrent pilonidal sinus disease (PND) up till now. The aim of this study is to evaluate the efficacy of bilateral gluteal fascio-myocutaneous advancement flap in treatment of recurrent cases of PND.

Patient and methods: 40 patients (34 males, 6 females) with recurrent PND were admitted and treated by bilateral gluteal fascio-myocutaneous advancement flap in the period of March 2012 to March 2015. The primary outcome was the incidence of recurrence of PND and the secondary outcomes included postoperative complications, patient's satisfaction, and quality of life after the procedure.

Results: Patients had a mean age of 25.5 ± 6.5 and a mean body mass index (BMI) of 28.4 ± 2.7. The mean duration of complaint was 14 ± 3.5 months. The mean operative time was 87 ± 13 minutes and the mean length of hospital stay was 4 ± 0.72 days. Follow up of patients was conducted for a mean period of 15.8 ± 4.9 months. Recurrence was detected in 2 (5%) patients within the follow up period. Thirty eight (95%) patients were satisfied by our procedure at the end of our follow up period and 62.5% of patients resumed their daily activities within one week.

Conclusion: Bilateral gluteal fascio-myocutaneous advancement flap proved to be an effective procedure in the treatment of recurrent sacrococcygeal PND with relatively low recurrence rate and acceptable morbidity.

Keywords: recurrent pilonidal sinus, pilonidal disease, flap surgery, gluteal advancement flap.
Short and long term impact of laparoscopic conversion in colorectal cancer surgery

Nader Francis, Nathan Curtis, Emma Noble, Emad Salib, Rob Hipkiss, Richard Dalton, Andrew Allison and Jonathan Ockrim

Yeovil District Hospital Foundation Trust, SOMERSET, UK

Purpose

Laparoscopic techniques in colorectal cancer surgery have been widely accepted due to short term patient benefits. Patients in whom the operation is converted to a laparotomy may have a worse short term outcome than after a successfully completed laparoscopic procedure. The aim of this study was to investigate the impact of conversion following colorectal cancer resection.

Method

A prospectively populated colorectal cancer patient database at Yeovil District Hospital UK was reviewed. Operations were performed or closely supervised by fully trained laparoscopic surgeons. Conversion was defined as the inability to complete the dissection laparoscopically (including the vascular ligation) and or requiring an incision larger than that required to remove the specimen. Overall survival (OS) was calculated by Kaplan-Meier at 5 years.

Results

1023 patients underwent colorectal cancer resection between 2002 and 2015 (median age 73 [25-96], 454 (44%) female), 423 (41%) were for rectal malignancies. Median follow up was 48 months (range 0-168). 854 (83.5%) were planned operations and 169 (16.5%) performed as emergencies. Patient demographics were equal between both laparoscopic and open, but the latter group contained higher stage cancers (p=0.027). 513 patients (50%) underwent laparoscopic surgery with 108 requiring conversion (21% elective vs. 28% emergency, p=0.311). Male gender (p=0.006) and advanced tumour stage (p<0.001) were associated with higher conversion rate but age (p=0.61) and tumour site (colon vs. rectum p=0.33) were not. Length of stay was shorter in the laparoscopic group compared to converted and open cases (median 7 vs. 9, p=0.001). Readmission rate was lower in completed laparoscopic cases (p=0.005). Five year OS was superior in the laparoscopic group compared to converted and open cases (78% vs. 65% vs. 62% respectively, p<0.0001).
Conclusion
A completed laparoscopic colorectal resection is associated with a shortened length of stay, less readmissions and a higher long term overall survival than those who are converted or undergo an open resection.

35) Effect of Age, Gender, and Type of Trauma on the Correlation between the Volume of Sphincter Defect in Endorectal Ultrasound and Anorectal Manometry in Cases of Post-Traumatic Fecal Incontinence

By Dr. Sameh Hany
Mansoura Faculty of Medicine

Abstract

Background and objective: Physiologic assessment of the anal sphincters in cases of post-traumatic fecal incontinence (FI) is a crucial step in the planning of surgical treatment. The aim of the this study is to assess the correlation between the volume of anal sphincter defect detected by endorectal ultrasound (ERUS), anal pressures measured by anorectal manometry and clinical symptoms assessed by Wexner continence score in patients with post-traumatic FI and also to study the effect of patient’s age, gender and type of trauma on this correlation.

Methods: Records of 70 patients fitting the eligibility criteria of the study were collected retrospectively from the archives of colorectal surgery unit of Mansoura University hospitals in the period of April 2010 to September 2015. Demographic data of patients, cause of trauma, ERUS images of the sphincter defects, anal resting and squeeze pressures as well as Wexner continence score were collected and correlation analysis was done.

Results: Seventy patients (54 males; 16 females) with a mean age of 35.7 ± 15.7 were investigated. The mean maximal resting anal pressure (MRP) was 42.27 ± 16.11 and the mean maximal squeeze anal pressure (MSP) was 79.97 ± 35.57. The mean Wexner score was 14.8 ± 4.2. There was a weak negative correlation between the volume of external anal sphincter (EAS) defect and the MSP overall (r = -0.4298). The strength of this negative correlation increased significantly in females, patients above 50 years, post-fistulectomy patients and female patients with obstetric injuries with a correlation coefficient of -0.5726, - 0.5619, -0.6384 and -0.6556, respectively.

Conclusion: The volume of defect of EAS is negatively correlated with the MSP and positively correlated with symptoms score. This correlation is stronger in females, elderly patients above 50 and patients with post-fistulectomy or obstetric injuries, this implies that this group of patients requires further assessment before planning surgical repair.

36) Rectal injuries

By Dr. Walaa Ghamrawy
Dr. Saleh D. Balawy
ABSTRACT:
Rectal injuries whether extra or intra-peritoneal is not a common occurrence. The controversy usually to divert or not to divert. We presenting two cases Knife Assault and one Iatrogenic Injury. Managed in different way.

10- Panel IV Missed Injuries
11- Panel V Acute Biliary Pancreatitis
12- Panel VI Antibiotics 2016 Guidelines
13- Pfizer Lecture
14-Panel VII Outcome and quality of life after different bariatric procedures
15- Session 6 Miscellaneous

37) Effect of size bougie on outcome of sleeve gastrectomy
Abd El Fattah Morsi, lecturer of general surgery, Al-Azhar University

Abstract
Aim: Sleeve gastrectomy is presently considered as effective as the current gold standard operation, the Roux-en-Y gastric bypass. The only absolute contraindication to this procedure is presence of Barrett’s esophagus. Though technically less complex than the gastric bypass, meticulous technique and avoidance of certain pitfalls are essential to achieve an optimal outcome and minimize serious complications including leaks. It is recommended to adopt an unhurried approach during stapling to avoid narrowing at incisura angularis and other complications. Most bariatric surgeons agree that standardization of sleeve gastrectomy diameter and hence volume with a bougie or orogastric tube is important. There is, however, no universal agreement regarding the ideal size of the bougie so we aim to have average range size of bougie with accepted outcome with less complications.

Materials and methods: The study was done prospectively on 30 cases of obese patients with different of BMI and different bougie size were used ranged from 32 to 42 French and follow up to patients was done up to one year as regard excess weight loss, complications mainly (leakage and stricture) or regain of weight.

Results:
After follow up of the patients there is no significant difference in BMI, excess weight loss or change in co-morbidities at 1 year when comparing patients who had sleeve gastrectomy with a 42 French versus
those who in whom a 32 French bougie was used. Outcome of surgery depend mainly on perfect of surgery technique rather than size of bougie either stapling line was done loose to the bougie or tight to it and this was reflected on excess weight loss and complication.

**Conclusion:** Size of bougie ranging from 32 to 42 French has no significant difference on outcome as regard weight loss and complication.

38) **Abdominal wall mass**

By Dr. Faye Abdulkareem

Dr. Saleh D. Balawy

**Abstract**

Abdominal wall tumor mostly either lipoma’s or desmoid tumor. We presenting this case in view of misleading history of 22-years-old female, on infertility and medication the rapid growth in last two months. And true cut biopsy all this focused our attention on desmoid tumor.

Contrary to the final histology.
39) Delayed presentation of post-traumatic diaphragmatic hernia presented by acute gastric outlet obstruction (case report)

Fahmy H., Dradka M., Taha A., A.Wahab M. Royal Commission medical center, Yanbu, KSA.

Introduction: The exact incidence of post-traumatic diaphragmatic hernia is difficult to define. The reason is that a significant number of cases of traumatic diaphragmatic rupture is clinically and radiologically overlooked early after injury.

Case report: We are presenting a case of a 35 years old Saudi lady who was transferred to our emergency department with acute onset of chest pain, dyspnea, tachypnea, and desaturation during the last twenty-four hours. She had a past history of road-traffic accident 5 years ago, with no history of surgery, or defined intra-abdominal post-traumatic lesion. During the last 2 years, the patient used to complain of recurrent attacks of chest pain, and vomiting after meals. No significant weight loss was reported. Since 72 hours, she started to vomit coffee-ground vomitus associated with epigastric pain that gradually increased until she developed a picture of acute gastric outlet obstruction, left lung collapse, and shift of mediastinum to the right side. Upon arrival to emergency department, the patient was dehydrated, acidotic, and screaming of chest pain, desaturated, and tachypnic. She was admitted to the intensive care unit, where correction of her fluid and electrolytes started. Her portable x-ray chest showed complete collapse of left lung, and right-sided mediastinal shift due to total migration of the stomach intra-thoracically. CT scan with IV contrast done, and revealed migration of the stomach, spleen, omentum, and splenic flexure of the colon to the left hemi-thorax with left lung collapse, right- sided mediastinal shift, with complete gastric outlet obstruction. The patient was transferred to operation room where left sided thoracotomy done through sixth left inter-coastal space. The stomach was evacuated by a gastrotomy and two liters of bloody gastric contents aspirated. The gastrotomy was closed in two layers and all intra-thoracic migrated abdominal organs were repositioned back to the peritoneal cavity through a large diaphragmatic defect of about 10cm in diameter. The defect was then closed by prolene zero continuous stitching, and a chest tube was left intra-pleurally after complete expansion of the left lung. The patient did well post-operatively.

Conclusion: Diagnosis of traumatic diaphragmatic rupture requires a high index of suspicion and good knowledge of the exact mechanism of trauma. Because of overlooking of traumatic diaphragmatic rupture early after trauma, complications such as traumatic diaphragmatic hernia should be treated surgically once diagnosed to avoid possible life-threatening acute complications.
Abstract

40) Hyperbilirubinemia post-living donor liver transplantation (LDLTx) is an ominous sign for early survival

Islam Ayoub, Hany Shoreem, Ahmed Sallam,, Taha Yassien Ibraheem AbdelKader, Osama Hegazy, Hossam Soliman, Sherif Saleh, Mohammed Taha, Amr Mostafa, Emad Hamdy, Hazem Lasheen, Tarek Ibrahim, Khaled Abou El-Ella

Hepato-pancreato-biliary surgery department, National Liver Institute, Menoufia University

□ Background:
Jaundice is a common sequel of LDLTx, etiological factors of post-LDLTx jaundice are multifactorial and varies according to the time of occurrence, so we study the etiological factors of persistent hyperbilirubinemia post-LDLTx and its impact on early survival.

□ Methods:
From April 2003 to December 2011, 150 patients had undergone LDLTx at the National Liver Institute, Menoufia University, factors affecting persistent hyperbilirubinemia after LDLTx were evaluated by univariate and multivariate analysis. Mortality was analyzed using Kaplan-Meier survival curve.

□ Results:
- 84 patients (56%) of the patient who had undergone LDLTx, developed hyperbilirubinemia. Factors of persistent hyperbilirubinemia represents that vascular complications accounts for the majority of causes of hyperbilirubinemia post-LDLTx (23 cases ~ 27%), followed by postoperative sepsis which accounts for 16% (14 cases).
  - Bile leak occurred in 15 cases (18.9%).
  - Small for size accounts for 15% of the cases with hyperbilirubinemia.
  - Acute cellular rejection occurred in 7 cases (8%).
  - Ischemia reperfusion injury occurred in 3 cases (3.6%).
- Multivariate analysis of factors of hyperbilirubinemia revealed that recipient gender, actual graft recipient weight ratio (GRWR) less than one, multiple hepatic venous anastomosis, acute cellular rejection & duct to duct biliary reconstruction were independent risk factors.
- Incidence of hyperbilirubinemia in the perioperative period decreases patient survival as 53 cases (63%) of patients who had developed hyperbilirubinemia, eventually died.

□ Conclusion:
Hyperbilirubinemia post-LDLTx indicates poor outcome and poor survival. Early management of hyperbilirubinemia improves the outcome. Avoidance of steatotic grafts, small for size & GRWR < 1 improves the incidence of early post-LDLTx Jaundice.
41) Post Bariatric Abdominoplasty

By Khaled Nowair , MD. Head of surgery department. Fellowship trainer. El- Mahalla Hospital.

BACKGROUND : Massive weight reduction in bariatric patients will be followed by skin redundancy, muscle diastasis, abdominal wall laxity and monspubis ptosis. Her the goal of abdominoplasty procedures is to improve the contour and shape of the abdomen via skin resection and redraping, subcutaneous tissue reduction, correction of muscle diastasis and abdominal wall laxity. Complications as flap necrosis, waist deformity, umbilical deformity and necrosis, seroma, hematoma, monspubis ptosis, abnormal scars, infection, nerve damage and delayed wound healing.

AIM: the focus of my presentation is how to deal with these problematic and complicated cases of abdominoplasty, the various possible approaches are discussed in each situation or patient and conclusions drawn.

CONCLUSION: these approaches provided excellent aesthetic outcomes with low morbidity.

42) Hand Injuries, ABC Management

By Dr. Magdy Nabil Morsy, M.D, FRCS Professor of Plastic and Hand Surgery, Military Medical Academy

Hand is Primary tool of Human. It help us eat, dress, write, earn a living and create art. To do these tasks and activities, our hands require sensation and movement, such as joint motion, tendon gliding, and muscle contraction.

Hand injuries are common and account for 5-10% of emergency department (ED) visits nationwide. The complexity of the hand and the similarities in clinical presentation of different injuries make understanding of hand anatomy and function, good physical examination skills, and knowledge of indications for treatment indispensable for the emergency physician.

Soft tissue injuries of the hand rarely are life threatening. However, the high incidence of disability from chronically painful or unstable joints is reflected by the fact that hand derangements account for 9% of all worker compensation claims.

The costs for treating these injuries are considerable and include not only the direct costs of repair but also the indirect costs borne by the patient, his or her family, and society. These indirect costs include, for example, time off from work and costs incurred while seeking care.
Double Y Pyloromyotomy versus Ramstedt's Pyloromyotomy in Management of IHPS. 

Abstract

Introduction: Various treatment modalities have been applied for the management of infantile 
hypertrophic pyloric stenosis. However surgery remains the mainstay of treatment for IHPS of which 
Ramstedt's pyloromyotomy remains the surgical technique of choice.

Patient and methods: A prospective randomized study of 60 patients with IHPS was done at paediatric 
surgery unit at Minia university hospital over a period of 2 years from September 2012 to December 
2014. The patients were divided into 2 equal groups of 30 patients in each. All patients selected for study 
were optimized preoperatively regarding to hydration, acid-base status and electrolytes imbalance. All 
surgeries were performed after obtaining informed consent. Standard preoperative preparation and 
postoperative feeding regimes were used. The patients were operated on an alternate basis, i.e., one 
patient by Double-Y Pyloromyotomy (DY) and the next by a Ramstedt's Pyloromyotomy (RP). Data on 
patient demographics, operative time, anaesthesia complications and postoperative complications 
including vomiting and weight gain were collected. Patients were followed up for a period of 3 months 
postoperatively.

Results: A total of 60 patients were included in the study. 30 underwent Ramstedt's pyloromyotomy 
(RP) and 30 had a double-Y pyloromyotomy (DY). No significant statistical differences were found in 
the patient population with regard to age (DY Group 49.2 ± 23.06days vs. RP Group 51 ± 
13.08days; p =0.538), sex (DY 6F/24M vs. RP 10F/20 M), weight at presentation (DY3.37 ± 9.41kg vs. 
RP3.38 ± 3.91; p =0.442). However a significant difference between DY vs. RP groups was noted with 
regard to vomiting and weight gain. Patients were followed up for a period of 3 months postoperatively. 
Vomiting in double-Y(DY) pyloromyotomy group (1.21 ± 0.45days) vs Ramstedt's pyloromyotomy (RP) 
group (3.03±0.37days) (p= 0.0001). Weight gain after 1st 10 days DY vs RP is (340 ± 117.37gm vs 230 ± 53.74 gm (p=0.035), after 1 month 1570 ± 196.07.

Conclusion: Double-Y pyloromyotomy(Alayet's pyloromyotomy) may offer a better functional outcome 
as seen by the lower frequency of vomiting in this study. The increased weight gain in the double-Y 
group may also indirectly indicate a wider and more effective opening of both ends of the pyloric canal. 
However more studies are needed to assess this new technique.

Key words : Pyloric stenosis , Double Y pyloromyotomy , Ramstedt's pyloromyotomy
INTRODUCTION:
Hypertrophic pyloric stenosis (HPS) is a condition affecting infants, in which the pyloric portion of the stomach becomes abnormally thickened and manifests as obstruction to gastric emptying. The infant presents in the first 2 to 12 weeks of life with forceful or projectile non-bilious vomiting after feeding. With protracted vomiting, the emesis may become blood-tinged because of gastritis. Jaundice occurs in about 2% of infants with HPS secondary to defective hepatic glucuronyl transferase activity, which resolves after surgery(1). IHPS is a common cause of gastric outlet obstruction in infants and the prevalence ranges from 1.5-4.0/1000 live births among whites though the incidence is lower in black Americans and Asians(2). The male to female ratio is ranges between 2:1 and 5:1(3). The majority of cases present between the 3rd and 5th week of age, although some cases are diagnosed at birth (2) and some have even been diagnosed in utero(4). The basis for higher male susceptibility is unknown. There is evidence both for and against an increased incidence in the first-born child, and there is familial clustering of IHPS, but not in a Mendelian pattern(6). IHPS appears to be more common in bottle-fed infants (7). In rural populations(5) and in the summer months (Langer and coworkers, unpublished data). Although IHPS is the most common surgical condition producing emesis in infancy(1), its etiology is unknown. Whether the condition is congenital or acquired is debated. Variations in IHPS incidence, trending over time, suggest that unknown environmental factors have an impact(5). Deficiency of nerve terminals, markers for nerve-supporting cells, peptide containing nerve fibers, mRNA production for nitric oxide synthase and interstitial cells of Cajal have all been found in the muscular layer of the pylorus(8), as well as increased insulin-like and platelet-derived growth factors (9,10). This abnormal innervation is postulated to lead to failure of relaxation of the
pylorus muscle, increased synthesis of growth factors, and subsequent hypertrophy\(^{(11)}\). It is likely that a spectrum of genetic mutations involving the production of nitric oxide may be responsible for many cases of IHPS \(^{(12)}\).

Various treatment modalities have been applied for the management of infantile hypertrophic pyloric stenosis. However surgery remains the mainstay of treatment for IHPS of which Ramstedt's pyloromyotomy remains the surgical technique of choice. Here a new technique focusing on pylorus, which may offer better results for this common condition. Alalayet et al \(^{(13)}\) introduced this new technique known as Alayet's Double-Y Pyloromyotomy.

**PATIENT & METHOD**

A prospective comparative study was conducted in the Paediatric Surgery Unit at Minia University hospital during the period between September 2012 and December 2014. Sixty cases of IHPS were included in the study. Thirty cases were operated by Double Y pyloromyotomy technique (Group1) and the other 30 cases were operated by Ramstedt's pyloromyotomy technique (Group2). Infant less than 3 months were included in the study while patients with other congenital problems or comorbid medical conditions were excluded from the study and all patients selected for the study were optimized preoperatively with regard to hydration, acid-base status and electrolyte imbalance. Standard preoperative preparation and postoperative feeding regimes (1st feed 12 hours after surgery with dextrose water moving to half-strength milk and proceeding to full feeds within the first 24 postoperative hours) were used. All surgeries were performed after obtaining informed consent. Patients were randomized at a ratio 1:1. All patients were operated using the standard right upper quadrant (RUQ) transverse incision. Information on patient's demographics, operative time, anaesthesia complications, postoperative vomiting and weight gain were collected. Parents were provided with a vomiting record sheet and were recorded the number of vomits per day and for how long vomiting took place.
postoperatively. Patients were followed up for a period of 3 months postoperatively. Data was collected and results were expressed as mean ± SD.

**TECHNIQUE:**
Ramstedt's pyloromyotomy had been done in the standard manner using the right upper quadrant transverse incision. In the double-Y pyloromyotomy (Alayet's pyloromyotomy), the incision was similar like a right upper quadrant transverse incision was used. The hypertrophoid pylorus was delivered and holding with thumb and index. A straight incision was made along 70% of the length of the hypertrophied pylorus in the centre. The sides were made like a V and each V represented the remaining 15% of the incision length. The final appearance of the incision resembled double-Y. The straight line was dilated first by using the reverse sides of an artery forceps, then V-incision were dilated for pouting of mucosa. After checking of any mucosal perforation, abdominal closure was closed in layers.

**RESULTS:**
A total of 60 patients were included in the study. 30 underwent Ramstedt's pyloromyotomy (RP) and 30 had a double-Y pyloromyotomy (DY). The operative time was the same and no intraoperative complications occurred apart from mucosal perforation which occurred in 4 cases in the group operated by Double-Y pyloromyotomy (DY) technique while occurred in 2 cases in the group operated by Ramstedt's pyloromyotomy (RP) technique. No wound infections were encountered and no redo- pyloromyotomies were needed. No significant statistical differences were found in the patient population with regard to age (DY Group 49.2 ± 23.06 days vs. RP Group 51 ± 13.08 days; p =0.538), sex (DY 6F/24M vs. RP 10F/20 M), weight at presentation (DY 3.37 ± 9.41 kg vs. RP 3.38 ± 3.91; p =0.442), symptoms and clinical condition including electrolyte imbalance and acid-base...
status (All patients were optimally corrected before proceeding to surgery). Both groups were also equal in terms of general anaesthesia. However a significant difference between DY vs. RP groups was noted with regard to vomiting and weight gain. Patients were followed up for a period of 3 months postoperatively. Vomiting in double- Y(DY) pyloromyotomy group (1.21 ± 0.45 days) vs Ramstedt's pyloromyotomy (RP) group (3.03±0.37 days) (p= 0.0001). Weight gain after 1st 10 days DY vs RP is (340 ± 117.37 gm vs 230 ± 53.74 gm (p=0.035), after 1 month 1570 ± 196.07 gm vs 990 ± 206.55 gm, (p=< 0.001)

No long-term complications were reported and no re-do pyloromyotomy was needed.

**DISCUSSION:**

Infantile hypertrophic pyloric stenosis (IHPS) was first described by Blair (14) in an autopsy specimen. A few other reports were published over the next 100 years, but the first detailed account was given by Hirschprung (15). IHPS remained an untreatable and usually fatal condition until 1907. First successful surgery was performed by Dufour and Fredet (16). They suggested splitting the muscle and then suturing transversely. However Ramstedt’s (17) described the classical operation and stated that there was no need for muscle closure and the procedure has remained in general use up until the present day. Here a new technique focusing on pylorus, which may offer better results for this common condition. Alalayet et al (13) introduced this new technique known as Alayet's Double-Y Pyloromyotomy. The exact aetiology is unknown and why this usually occurs in the first-born child is also a question that still awaits an answer. Persons with a positive familial history and certain ABO blood groups show a higher incidence. Among the acquired factors, the methods of feeding (breast versus bottle) and seasonal variability have been implicated (18). Prenatal prescription of macrolides has been implicated in the pathophysiology of IHPS (19). Decreased numbers of interstitial cells of Cajal and heme oxygenase-2 have been found in the
smooth muscle of IHPS (20). Increased vascularity has been shown to be an integral component of the pylorus in IHPS (21). An increased amount of desmin in the hypertrophied pylorus may be the cause of in-coordination of contraction and relaxation (22). Management has come a long way from simple observation to treatment with intravenous atropine sulphate although this is not favored by most centers (23). Traumamyoplasty (crushing with Babcock forceps) has been carried out satisfactorily at few centres (24). Endoscopic balloon dilatation and endoscopic pyloromyotomy using endoscopic electrosurgical needle or a sphincterotome (25) have also been described. However surgery remains the mainstay of the treatment and is safely and routinely done at most centres. The classical Ramstedt's procedure is conventionally done through a right upper transverse incision. Tan and Bianchi (26) modified it to be done through a supra-umbilical semicircular incision for better cosmesis. An umbilical sliding window technique introduced in Japan has reduced the incidence of postoperative wound infection further than the Bianchi procedure (27). A right semicircular umbilical technique offered superior results, especially for large tumours compared to Bianchi's procedure (28) with much less damage to the pylorus and superior results in terms of infection. A squeeze technique is useful especially for the delivery of large pyloric tumors through the supra-umbilical route (29). Transumbilical pyloromyotomy has been described as an alternative to laparoscopy (30). Since a significant period of time pyloromyotomy have been carried out laparoscopically. Double-Y pyloromyotomy also can be done laparoscopically. In this study postoperative vomiting is significantly less in the double-Y group compared to the Ramstedt procedure group. The weight gain in the patients is comparable to that in a study done a few years ago (31). Double-Y pyloromyotomy (DY) had proved to be equally safe and efficacious compared to the Ramstedt's procedure. The
method is suitable for both conventional and laparoscopic surgery.

**CONCLUSION:**

Double-Y pyloromyotomy seems to offer a better and wider opening of the pylorus by creating a wider opening of the pyloric canal at the ends with a wide angle compared to other methods like Ramstedt's pyloromyotomy, where the ends are sharply narrowed. A double-Y pyloromyotomy (Alayet's pyloromyotomy) may offer a better functional outcome as seen by the lower frequency of vomiting in this study. The increased weight gain in the double-Y group may also indirectly indicate a wider and more effective opening of both ends of the pyloric canal.

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44) **US-guided Injection of Charcoal Suspension:** A simple method of surgical localization for non-palpable suspicious breast lesions

Omar Farouk1*, Mohamed Ezzat1, Adel El-Badrawy2, Tamer Fady1, Wagdi El-Kashef3, and Nazem Shams1

1Surgical Oncology Department, Oncology Center, Faculty of Medicine, Mansoura University, Egypt
2Radiology Department, Faculty of Medicine, Mansoura University, Mansoura, Egypt
3Pathology Department, Faculty of Medicine, Mansoura University, Mansoura, Egypt

*Corresponding Author:
Omar Farouk (M.D, IMRCS & EBSQ)
Assistant Professor of Surgical Oncology
Oncology Center- Mansoura University (OCMU), Mansoura, Egypt
Email: dr_omarfarouk@yahoo.com
Cell Phone: 002 01226902626

**Abstract**

**Introduction:**
With the increased utilization of national screening programs, breast cancer is more frequently being detected as radiographic non-palpable lesions (up to 50%). Moreover, the sizes of tumors detected have decreased in recent years, increasing the need for the accurate image-directed localization for surgical excision in a significant portion of cases. Although Wire guided localization (WGL) has been the most commonly used method for many years, inherent problems remain. The surgeon is often unable to confirm the exact site of the lesion in the breast. Scheduling conflicts between the surgeon and the radiologist can occur, resulting from the need to coordinate multiple procedures on the same day with different teams. There is an inability to use wire localization for the first start time in the morning without a significant delay in the operating room. However, till now there is no agreement about the most appropriate or standard method of
surgical localization. This encourages us to use US-guided injection of Charcoal aqueous suspension which is simple and cheap method of surgical localization of non-palpable suspicious breast lesions.

**Patients & Methods:**
This prospective study included 18 patients presented with non-palpable suspicious breast lesion (BIRADS 4 or 5) in Oncology Center Mansoura University (OCMU), during the period between June 2014 & October 2015.

All patients were injected with 1-3 ml of sterilized 3% aqueous suspension of charcoal granules under guidance of US at the superficial border of the suspicious lesion and the track between the lesion and the needle entry point in the skin which occur at the future incision.

**Results:**
The median age was 43 years (range; 36 - 50). Two patients presented with bifocal lesions; so the study included 18 patients with 20 suspicious lesions (6 with BIRADS 4a, 7 with BIRADS 4b, 4 with BIRADS 4c, and 3 BIRADS 5). The largest diameter of these lesions ranged between 4 - 15 mm (Mean 10.9 mm).

Postoperative pathology revealed 8 malignant lesions and 12 benign lesions. Among benign lesions there were; 9 with fibroadenosis with epitheliosis, 2 with lobular mastitis, one with lobular hyperplasia. All 6 BIRADS 4a lesions proved to be benign. Among malignant lesions there were; 2/7 BIRADS 4b lesions (28.5%), 3/4 BIRADS 4c lesions (75%) and 3/3 BIRADS 5 lesions (100%).

All 12 benign lesions (in 11 patients) were managed by Wide Local Excision (WLE) and 8 malignant lesions (in 7 patients) were managed as; 4 patients had CBS, 2 patients (past history of MRM) had MRM and one patient had Nipple Sparing Mastectomy (NSM) & Immediate breast reconstruction by Latissmus Dorsi Flap (LDF), due to failure to achieve free safety margins in conservation. There was no reaction nor infection reported in our study.

**Conclusion:**
Charcoal suspension has many advantages as a method of surgical localization, being due to; Low cost, No reaction reported, accurate & rapid, no tissue dispersion, no interference with histology and Tattoo help surgical localization. However, large needle should be used in injection in order to prevent obstruction by carbon particles. In our patients, this method yields a satisfactory practice and outcome without any morbidity.

**45) Accuracy of Sentinel Lymph Node Biopsy After neoadjuvant Chemotherapy in Breast Cancer Patients; single center experience.**

**Full Title:** Accuracy of Sentinel Lymph Node Biopsy After neoadjuvant Chemotherapy in Breast Cancer Patients; single center experience.

**Article Type:** Research **Corresponding Author:** Omar Hamdy Oncology center, Mansoura University omarhamdv87@gmail.com +201003526752

**First Author:** Omar Hamdy **Order of Authors:** Omar Hamdy Waleed el nahas Sameh Roshdy Khaled Abdel-wahab
Abstract

Introduction: Most important factor affecting prognosis of breast cancer is axillary nodal involvement. Standard of care for axillary nodes staging is Sentinel lymph node (SLN) biopsy. Several studies assessed accuracy of SLNB after neoadjuvant chemotherapy in patients with breast cancer. In this study, we evaluated the feasibility of SLNB in predicting axillary lymph node status in breast cancer patients after neoadjuvant chemotherapy. Patients and methods: 45 female patients with resectable, non-metastatic breast cancer who received neoadjuvant chemotherapy were enrolled according to the routine Mansoura Oncology Center guidelines of management of breast cancer. Methylene blue dye used for detection of SNL.

Results: Successful SNL detection was 82.2 %. Univariate analysis of clinicopathologic features associated with failure to identify an SLN revealed that skin involvement (T4b disease) was associated significantly with a decreased likelihood of identification (P= 0.005). False negative rate equals 11/21 = (52.3 %). With advancement of the stage of the tumor, the incidence of false negative results increases significantly (P= 0.012) with 95% confidence interval; 1.2 - 5.4.

Discussion: The only significant factor for non-identification of sentinel LNs was persistence of skin manifestations (especially peau d'orange) after neoadjuvant chemotherapy in patients who were first presented by T4 lesions before chemotherapy. The most probable explanation for that result is that one of the pathological characters of T4 breast cancer is invasion of dermal lymphatic by tumor emboli, which can lead to lymphatic obstruction causing the clinical picture of peau d'orange, rapid breast enlargement and diffuse erythema.

Conclusion: SLNB should be adopted to be the standard method for axillary staging with T1-3 tumors after receiving neoadjuvant chemotherapy. In T4 patients, it is associated with low detection rate & high false negative rate making it doubtful technique for axillary staging.

46) Single incision laparoscopic pediatric inguinal hernia repair

Rafik Shalaby*, Maged Ismail*, Sameh Shehata**, Ibrahim Gamaan*
Abdelaziz Yehya * Ibrahim M. Elsayaad*, Mabrouk Akl* and Abdelmonaem Shams Eldin*, Pediatric Surgery Department, Al-Azhar University* and Alexandria University**

Abstract

Background: The desire to reduce incision related morbidity and pain while achieving improve cosmetic results has recently led to the introduction of single incision pediatric endosurgery [SIPES]. Over the last few years, SIPES is increasingly used for a variety of procedures; single incision laparoscopic hernia repair [SILHR] is perhaps its common applications. Intracorporeal suturing and knot tying during SIPES remain one of the most challenging tasks. The aim of this study is to present a novel technique to avoid excessive purposeless movements during SILHR in children [Shalaby
**Technique.** **Patients and Methods:** One-hundred and fifty patients with 170 hernial defects were subjected to SILHR during the period from June 2009 to October 2011. Extraperitoneal saline was injected around internal inguinal ring [IIR] in males. The opened IIR was closed by percutaneous insertion of purse string suture using Reverdin Needle (RN) with intracorporeal suture tie. The main outcome measurements were; feasibility of the technique, tightness of the suture tie, operative time, postoperative hydrocele formation, recurrence rate, and cosmetic results. **Results:** Ages ranged between 6 months and 7 years (mean 2±24.2 years). They were 101 males and 49 females. Eighty-four patients presented with right sided inguinal hernia, 46 patients with left sided hernia, and 20 patients with bilateral hernia. The mean operative time was 12.4±1.7 minutes for unilateral cases and 18.6±1.7 minutes for the bilateral cases. On follow-up, there was only 1 case of recurrence and 3 cases of hydrocele and the scar is nearly invisible. **Conclusion:** The preliminary results of this study showed that our technique is very promising to achieve secure closure of IIR and reduced operative time with excellent cosmetic results

**Key Words:** Single incision laparoscopic surgery, Economy of movements, Inguinal hernia, Pediatric. Shalaby Technique

**Day 3: Friday April 15th, 2016**

16- Panel VIII Video Panel

17- Panel IX Trans-Anal Surgery- Technical Nuts and Bolts

18- Session 7 Hepato-pancerato-biliary II

47) **Risk factors impacting Mortality post living related liver transplant for hepatocellular carcinoma: A retrospective cohort study**

By Dr. Amr Aziz

Associate Professor of Hepato-pancreatico-biliary and Liver Transplant Surgery

**Abstract**

**Objective:** Liver transplantation is an optimal radical therapy for selected patients with hepatocellular carcinoma.

**Aim:** the aim of this study is to retrospectively identify and analyze the factors impacting the mortality of HCC patients after LDLT.

**Patients and methods:** This is a single center retrospective analysis of data collected from 205 patients, who underwent LDLTx in the department of surgery, National Liver Institute, Menoufia University,
between May 2004 and the end of December 2013. Of these patients, 53 patients proved to have HCC in the explanted liver. Preoperative evaluation included demographic data of the patients, Liver status, Tumor burden, and downstaging or bridging procedures. Intraoperative and postoperative data were collected and compared with mortality. Mortality was classified as Peri-operative mortality period: Mortality occurred within 30 days after operation, Early mortality occurred between 2-6 months post operatively and Late mortality occurred after 6 months from operation.

**Results:** The mean age of all patients was 48 ± 6.1 years, with 50 (94.3%) patients were male. During the follow-up period, 22 (41.5%) patients expired. The majority of mortality cases 10 (18.9%) were in Peri-operative mortality period, 6 (11.3%) patients died in Early mortality period and 6 (11.3%) cases were Late mortality period. there was a statistical significance between mortality of transplanted HCC patients and CMV negative IgG and TNM classification (III B). Concerning the operative data, there was a significant statistical relation between mortality and actual graft weight, actual graft GRWR, blood transfusion units, and plasma transfusion units. Pathologically, there was a significant statistical relation between mortality and tumor differentiation. In multivariate analysis, CMV-IgG negativity, TNM stage (stage III), actual graft weight and number of Blood transfusion units were independent predictors of mortality.

**Conclusion:** LT is the optimal treatment of HCC, and it has reached its phase of maturity with a better knowledge of the prognostic factors of HCC recurrence and mortality. CMV-IgG negativity, TNM stage (stage III), actual graft weight and number of Blood transfusion units were independent predictors of mortality.

48) **Postoperative Thrombocytopenia Aggravates Hepatic Dysfunction and Mortality after Liver Resection for Hepatocellular Carcinoma**

**Ashraf Mohammad El-Badry MBBCh MCh MD (Sohag) MD (Zurich)**

Consultant Hepato-Pancreato-Biliary Surgeon, Sohag University Hospital, Lecturer of Surgery, Sohag University

**Background:** Blood platelets are critical for stimulation of liver regeneration through their contents of serotonin. Reduced postoperative platelet count may contribute to deterioration of the clinical outcome after liver resection for hepatocellular carcinoma (HCC).

**Methods:** Medical records of patients who underwent liver resection at Sohag University Hospital (February 2012 - September 2015) were analyzed. Emergency and pediatric patients were excluded. Two groups of patients who were operated for HCC versus other indications and matched for gender, age, American Socitey of Anesthiologists (ASA) score and number of resected segments were identified. Incidence of reduced postoperative platelet count < 100,000/µL versus ≥ 100,000/µL, postoperative complications according to Clavien system, frequency of liver failure and mortality were compared between both groups. Statistical analysis was carried out by GraphPad Prism 6.0 software.
Results: Twenty patients were enrolled (ten patients per group). All patients in the HCC group were cirrhotics. Indications of liver resection in the non-HCC group entailed metastasis and benign liver lesions. Reduced postoperative platelet count < 100,000/µL was encountered only in HCC patients. This group exhibited higher complication rates (p< 0.05), increased length of intensive care unit stay (p< 0.05), higher levels of bilirubin and transaminases and reduced prothrombin concentration (p< 0.05). Mortality occurred only in HCC patients with reduced postoperative platelet count (two patients) compared with no mortality in the non-HCC group.

Conclusion: The increased susceptibility for reduced platelet count after liver resection in HCC patients is related to preexisting cirrhosis. Concomitant reduction in postoperative platelet count and liver cirrhosis are associated with worse clinical outcome after liver resection for HCC.

49) Malignant obstructive jaundice in the NCI Cairo University review of 232 patients.

Mohammed Gamil MD; Nelly Hassan Ali Eldin MD; Ali Hassan Mebed MD; Ashraf Sobhy Zakaria* M.Sc. (2013)

Surgical oncology department; biostatistics and cancer epidemiology department; surgical oncology department; surgical oncology department at National Cancer Institute Cairo University, Egypt.

*Corresponding author.tel:+20 01005843094.

E-mail address:ashrafsobhy27@yahoo.com.

Abstract

Background: Obstructive jaundice is a common problem in the medical and surgical gastroenterological practice. Malignant obstructive jaundice can be caused by cancer head of pancreas, periampullary carcinoma, carcinoma of the gall bladder and cholangiocarcinomas.

Objective: to review the etiological spectrum of malignant obstructive jaundice in NCI Cairo university during a period of 3 years (2008 till 2010).

Patients and methods: retrospective study including 232 patients who presented with malignant obstructive jaundice between (2008 to 2010).Data were collected from the biostatistics and cancer epidemiology department.

Results: out of 232 patients; 156 (67.2%) were male and 76 (32.8%) were female; the median age of the study population was 49 years (range 19_80years).

The commonest cause of malignant obstructive jaundice was pancreatic head cancer, 72% (167/232), followed by the ampullary carcinoma 15% (36/232).The last cause was cholangiocarcinoma12.5%
Regarding the commonest symptom; clay colored stools (98.7%) was more frequent in patients with malignant disease whereas abdominal pain (97.7%) was 2nd common symptom.

**Conclusion:** Obstructive jaundice is more common among males and cancer head of pancreas is the commonest malignancy. US, ERCP and CT-Scan are important diagnostic modalities for evaluation of patient with obstructive jaundice with ERCP having the additional advantage of being therapeutic as well.

**Keywords:** Obstructive jaundice, ERCP, Ca Head of pancreas, Ca gall bladder.

**50) Day-of-Surgery Rejection of Donors in Living Donor Liver Transplantation.**

**Bassem Hegab, Mohamed Rabei Abdelfattah, Ayman Azzam, Hazem Mohamed, Waleed AL-hamoudi, Faisal Aba Alkhail, Hamad Al Bahili, Hatem Khalaf, Mohammed Al Sofayan, Mohammed Al Sebayel**

**Abstract**

**AIM:** To study diagnostic laparoscopy as a tool for excluding donors on the day of surgery in living donor liver transplantation (LDLT).

**METHODS:** This study analyzed prospectively collected data from all potential donors for LDLT. All of the donors were subjected to a three-step donor evaluation protocol at our institution. Step one consisted of a clinical and social evaluation, including a liver profile, hepatitis markers, a renal profile, a complete blood count, and an abdominal ultrasound with Doppler. Step two involved tests to exclude liver diseases and to evaluate the donor's serological status. This step also included a radiological evaluation of the biliary anatomy and liver vascular anatomy using magnetic resonance cholangiopancreatography and a computed tomography (CT) angiogram, respectively. A CT volumetric study was used to calculate the volume of the liver parenchyma. Step three included an ultrasound-guided liver biopsy. Between November 2002 and May 2009, sixty-nine potential living donors were assessed by open exploration prior to harvesting the planned part of the liver. Between the end of May 2009 and October 2010, 30 potential living donors were assessed laparoscopically to determine whether to proceed with the abdominal incision to harvest part of the liver for donation.
RESULTS: Ninety-nine living donor liver transplants were attempted at our center between November 2002 and October 2010. Twelve of these procedures were aborted on the day of surgery (12.1%) due to donor findings, and eighty-seven were completed (87.9%). These 87 liver transplants were divided into the following groups: Group A, which included 65 transplants that were performed between November 2002 and May 2009, and Group B, which included 22 transplants that were performed between the end of May 2009 and October 2010. The demographic data for the two groups of donors were found to match; moreover, no significant difference was observed between the two groups of donors with respect to hospital stay, narcotic and non-narcotic analgesia requirements or the incidence of complications. Regarding the recipients, our study clearly revealed that there was no significant difference in either the incidence of different complications or the incidence of retransplantation between the two groups.

Day-of-surgery donor assessment for LDLT procedures at our center has passed through two eras, open and laparoscopic. In the first era, sixty-nine LDLT procedures were attempted between November 2002 and May 2009. Upon open exploration of the donors on the day of surgery, sixty-five donors were found to have livers with a grossly normal appearance. Four donors out of 69 (5.7%) were rejected on the day of surgery because their livers were grossly fatty and pale. In the laparoscopic era, thirty LDLT procedures were attempted between the end of May 2009 and October 2010. After the laparoscopic assessment on the day of surgery, twenty-two transplantation procedures were completed (73.4%), and eight were aborted (26.6%). Our data showed that the levels of steatosis in the rejected donors were in the acceptable range. Moreover, the results of the liver biopsies of rejected donors were comparable between the group A and group B donors. The laparoscopic assessment of donors presents many advantages relative to the assessment of donors through open exploration; in particular, the laparoscopic assessment causes less pain, requires a shorter hospital stay and leads to far superior cosmetic results.

CONCLUSION: Laparoscopic assessment of donors in LDLT is a safe and acceptable procedure that avoids unnecessary large abdominal incisions and increases the chance of achieving donor safety.
Small For Size Syndrome difficult dilemma: lessons from 10 years single centre experience in living donor liver transplantation


1- Hepatobiliary Surgery Department, National Liver Institute, Menoufiya University, Shibin El-Koum

Corresponding Author: Emad Hamdy Gad (1) Abstract

Background: sufficient function of undersized grafts is a major concern in living donor liver transplantation (LDLT). The term Small For Size Syndrome (SFSS) has been used to describe a variety of clinical presentations ranging from mild hepatic dysfunction with isolated hyperbilirubinemia to irreversible graft failure leading to death of the patient. It is proposed to divide SFSS into small-for-size dysfunction (SFSD) and small for size non function (SFSNF).

Objectives: to define SFSS, sub classification, pathogenesis, clinical presentation, risk factors, possible specific management and outcome of this syndrome.

Patients and methods: During the period from April 2003 to the end of 2013, 174 adult-to-adult LDLT (A-ALDLT) had been performed at National Liver Institute, Menoufiya University, Egypt. The records of these patients were retrospectively analyzed to study cases with SFSS.

Results: twenty (11.5%) recipient had been diagnosed to have SFSS, of whom 16 patients (80%) had SFSD and 4 patients (20%) had SFSNF. Hyperbilirubinaemia was the fixed presentation in 100% of cases followed by large volume of ascitis in 90%, then, coagulopathy in 85% of cases. While SFSG (> 0.8) was present in 9.7% (n=17/174), Graft size in SFSS cases were classified to extra-small (GRWR < 0.8) in 10 cases, small (GRWR ≥0.8 and < 1) in 5 cases and medium sized (GRWR ≥ 1) in 5 cases. The occurrence of the syndrome had been owed to transplantation of extra small graft in 10 cases, portal hyperperfusion in 3 cases, severe portal hypertension in 4 cases and outflow obstruction in 3 cases. While extra-small graft, Portal hypertension, steatosis and Lt lobe graft were signif icant predictors of SFSS in univariate analysis,only graft size were independent predictor of SFSS on multivariate analysis. Splenectomy was tried in 7 patients at the time of transplantation of extra-small graft aiming to prevent its occurrence. The SFSS related mortalities were recorded in 13/20 patients (65%).

Conclusion: SFSS is a major and difficult entity following LDLT with deadful outcome. Small graft represents the main obvious causing factor. Splenectomy may be used in cases with extra- small grafts to avoid SFSS but of controversial value and should be further studied before being addressed as a beneficial management for SFSS

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A Comparative Study between Surgical intervention versus Radiofrequency Ablation in Management of Patients with Hepatocellular Carcinoma

Hassan Ashour\textsuperscript{a}, Morsi Moommed\textsuperscript{b}, Wael Mansy\textsuperscript{c}, sameh saber\textsuperscript{d}, Wael Lotfy\textsuperscript{e} and Nawel Hussen\textsuperscript{f}

\textsuperscript{a} assistant lecturer of general surgery, \textsuperscript{b,c} general surgery consultant, \textsuperscript{d} interventional radiology consultant, \textsuperscript{e} assistant professor of general surgery, \textsuperscript{f} professor of general surgery faculty of medicine Zagazig University.

Abstract Hepatocellular carcinoma (HCC) is the fifth most common malignancy worldwide, and surgical hepatic resection (HR) is the preferred treatment option (Merle, 2005). However, favorable survival outcomes have been reported for patients with small HCCs following radiofrequency ablation (RFA) (N’Kontchou et al., 2009). Unfortunately, the majority of comparative studies conducted on HR and RFA as primary treatment options in HCC have been observational (Cho et al., 2011). The aim of this study was to prove or disprove the superiority of surgical resection over RFA regarding the efficacy and safety. Patients and methods Our prospective study was in Zagazig University Hospitals and was included 30 patients with hepatocellular carcinoma (HCC) (15 patients will be admitted for resection and 15 patients for radiofrequency ablation) during the period from November 2012 to October 2014. Results Total of 15 consecutive patients with HCC (11 males, 4 females; average age: 53.4; range: 45–62) underwent hepatic resection at Surgical Department. Total of 15 consecutive patients with HCC (12 males, 3 females; average age: 54.3; range: 48–66) underwent RFA interventional at Radiology Department. Additionally, 66.7% of resection group > 3 cm in tumor diameter vs. 73.3% RFA respectively. There was no significant difference in the tumor diameters between the two groups ($p = 0.69$) Operative mortality (within 30 days of surgery) for those patients who underwent resection was 5%; One- and 2-year survivals were respectively 86.7% and 66.7%, with 1- and 2-year disease-free survival of 80% and 53.3% respectively. There was no in-hospital mortality after RFA. One- and 2-year survival was, respectively, 80% and 33.3%, with 1- and 2-year disease-free survival of 60% and 20% respectively.

Conclusion Surgical resection for patients with HCC and liver cirrhosis Child A and tumor $\geq$ 3 cm is preferred than RFA. While the results of surgery and RFA were similar for patients with Child B disease.

Key words Hepato cellular carcinoma, liver resection, radiofrequency ablation
Management of Postoperative Bile Leak: Tertiary Centers Experience

Abstract

Background and aim: Bile duct leak is an infrequent but serious disorder. The great majority occurs after hepatobiliary surgery. Early recognition and adequate multidisciplinary approach is the cornerstone for the optimal final outcomes. Traditionally, surgery has been the gold standard for the management of bile leak, but it is associated with significant morbidity and mortality. Biliary endoscopic procedures have become the treatment of choice, as simple, noninvasive procedure, with low morbidity and mortality, short hospital stay, and cost effective, with demonstrated results comparable to those achieved with surgery. We aim to evaluate management of postoperative bile leak.

Methods and Material: In the period from Jan. 2005 to Dec. 2014, a random sample of 311 patients with postoperative bile leak from general surgery departments, and gastro-intestinal endoscopy units, Sohag and Assiut University hospitals were studied and evaluated.

Results: The definitive management of bile leak was done within 0-143 days. Patients were managed accordingly using, endoscopy in 232 patients (plus percutaneous techniques in 8 patients) and surgery in 79 patients. Endoscopic treatment proved very effective in 94.2% of the patients with simple bile leak and 44.3% of the patients with complex bile leak.

Conclusion: Endoscopic treatment substituted surgery in all simple bile leak cases as a competitive treatment. Surgical treatment was the definitive treatment of complex bile leak; however endoscopy was a mandatory complementary tool in initial management.

Evaluation of Open Surgical Resection versus Percutaneous Radiofrequency Ablation for Single Malignant Hepatic Focal Lesion

Taha H. Mahmoud M.B., B.Ch(1), Mustafa M. Mustafa MD(2), Moatasem M. Ali MD(3), Nasser M. Zaghoul MD(4), Salah A Al Razek MD(5)
(1) Assistant Lecture of general surgery-Minia University (2) Lecture of interventional radiology -
Abstract
Purpose: This study evaluates the treatment outcome of open hepatic resection versus percutaneous Radiofrequency Ablation regarding their feasibility, radicality and Morbidity and local tumor recurrence.

Methods: A prospective study of 30 patients their ages ranged from 40 to 70 years with single malignant hepatic focal lesion, hepatocellular carcinoma (HCC) admitted to hepatobiliary unit in Minia university hospital, were enrolled in this prospective randomized double blind study, 16 patients were subjected to percutaneous Radiofrequency ablation (group A) and 14 patients were subjected to open surgical resection (group B)

Results: Regarding to early recurrence two patients (12.5%) in Radiofrequency (RF) group after one year of follow up by Triphasic CT scan, one patients developed recurrence at same site and another patient developed recurrence at distant liver site. no recurrence detected in resection group.

Conclusion: Surgical resection remains the better choice of treatment for HCC as it is considered a potentially curative modality, whereas RFA should be considered as an effective alternative treatment when surgery is not feasible.

Keywords: Radiofrequency Ablation- Hepatic resection - Hepatic Focal Lesion

19- Panel X Non Traumatic Vascular Emergency