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EMERGENCY SURGERY DUE TO GASTROINTESTINAL METASTASES FROM ANAPLASTIC LUNG CANCER. REPORT OF TWO CASES

M. CARELLA*, A. GURRADO, G. DI MEO, A. GIRARDI, R.M. ISERNIA, L.I. SGARAMELLA, M. TESTINI

Dipartimento di Scienze Biomediche ed Oncologia Umana, Unità Operativa Dipartimentale di Chirurgia Endocrina, Digestiva e d'Urgenza, Università degli Studi di Bari "Aldo Moro", Bari, Italia

Objective: Lung cancer is the most important cause of tumor-related death worldwide. Gastrointestinal metastases from lung cancer are rare, and their reported occurrence varies from 0.5% to 10%. Starting from our experience we analyze clinical and pathological features of two patients affected by gastrointestinal metastases from lung cancer and we reviewed literature.
Methods: A 62-years-old man was admitted to our Academic Hospital with severe hypovolemic shock due to gastrointestinal bleeding and abdominal pain. In the second case, a 59-years-old man with intestinal occlusion, gastrointestinal bleeding and right palpable mass was also admitted. Laboratory analyses showed anaemia and leukocytosis in both cases. A CT-scan showed intraperitoneal free air and fluids, lung nodule and multiple metastatic lesions in one patient; in the second one it revealed a right lung neoplasm with huge right colon tumor infiltrating the abdominal wall and stomach. Both patients underwent bronchoscopy with BAL, brushing and surgery consisted of resection intestinal loop in the first, and total gastrectomy with right hemicolectomy in the second one.
Results: Patients were discharged on the 15th post-operative day and were introduced to chemotherapy. The histology confirmed the diagnosis of gastrointestinal metastases from anaplastic lung cancer. The first patient died 4 months after surgery, the second 3 months after.
Conclusions: The appearance of gastrointestinal metastases from anaplastic lung cancer is an extremely rare event. Surgical approach is mandatory even if it should be considered only as a palliative treatment for the aggressive behaviour of the disease.

A RARE CASE OF INTESTINAL CISTOIDES PNEUMATOSIS IN PATIENTS WITH CELIAC DISEASE. CASE REPORT AND SYSTEMATIC LITERATURE REVIEW

E. D'AMBROSIO*, M. TEDESCHI, G. DI MEO, A. FIORELLA, V. FERRARO, R.M. ISERNIA, L.I. SGARAMELLA, G. PICCINNI, M. TESTINI

Dipartimento di Scienze Biomediche ed Oncologia Umana, Unità Operativa Dipartimentale di Chirurgia Endocrina, Digestiva e d'Urgenza, Università degli Studi di Bari "Aldo Moro", Bari, Italia

Objective: Intestinal cystoides pneumatosis (ICP) is characterized by the presence of multiple gas-filled cysts within the wall of the gastrointestinal tract. The usual causes of ICP are vascular disease, mesenteric ischemia, bowel necrosis and obstruction. We present a case of ICP in a patient with celiac disease.
Methods: A 65 year-old man affected by celiac disease with chronic abdominal pain without peritoneal signs of acute abdomen was admitted in emergency to our Academic Hospital. A CT-scan showed abdominal effusion and free sub-phrenic air. Despite evidence of perforation, a small bowel resection with a mechanical side-to-side jejunal anstomosis was performed.
Results: The recovery was uneventful. Macroscopically the sections demonstrate a honeycombed appearance of multiple, thin-walled, collapsed cysts ranging in size from a few millimetres to several centimetres. The cysts mainly occupy the submucosa, but also the subserosal layer appearing like serosal bubbles. Sometimes inflammatory cells, including lymphocytes, macrophages and foreign body cells, surround the cysts. The mucosa overlining appears normal, although it may be thinned over a submucosal cyst. Histological diagnosis was intestinal cystoides pneumatosis. After 1-year follow-up the patient is still disease-free and in good health.
Conclusions: The association between celiac disease and intestinal cystoides pneumatosis is extremely rare (eight cases reported in literature). A demolitive approach as in this reported case should be also considered in selected cases.

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* *Presenting Author*

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AGGRESSIVE MESENTERIC FIBROMATOSIS IN FISHER EVANS SYNDROME: IS EXTREME SURGERY NEEDED? A CASE REPORT

A. DE LUCA*, G. LISSIDINI, E. D'AMBROSIO, A. FIORELLA, M. FANELLI, A. GIRARDI, A. PASCULLI, C. LORUSSO, M. TESTINI

Dipartimento di Scienze Biomediche ed Oncologia Umana, Unità Operativa Dipartimentale di Chirurgia Endocrina, Digestiva e d'Urgenza, Università degli Studi di Bari "Aldo Moro", Bari, Italia

Objective: Surgery is still the standard life-threatening treatment for mesenteric fibromatosis, also called desmoid tumor; this neoplasm does not metastasize but locally shows infiltrative growth. Correct diagnosis of this rare disease is the most important factor for prognosis as it can also improve morbidity.
Methods: A 35 years-old woman was admitted to our Academic Institution for bowel obstruction. Anamnesis showed a splenectomy for Fisher Evans's syndrome and an oophorectomy for hemoperitoneum due to a follicle's rupture. CT scan didn't show the exact site of the obstruction. At laparotomy, performed in emergency, a serious occlusive chronic inflammatory disease involving all the small bowel, and the right and transverse colon was found, with multiple intra-abdominal abscesses. A total resection of the small bowel, a right hemicolectomy and a gastrostomy with a jejunostomy located 15 cm. from Treitz ligament were performed .
Results: The patient had an uneventful post-operative course; histological examination revealed an aggressive mesenteric fibromatosis. 3 months later the patient showed a severe jaundice caused by sclerosing cholangitis histologically diagnosed. After 1 year the patient is still alive, in stable health condition , recovered from the jaundice and feed by total parenteral nutrition. Moreover, she is waiting for bowel and liver transplantation.
Conclusions: Management of desmoid tumor should be multidisciplinary. Moreover, surgery could optimize local tumor control and preserve the patients' quality of life. When fibromatosis is highly aggressive, like in this case, the treatment of choice should be extreme surgery, followed by multi-organ transplantation.

HUGE INFLAMMATORY FIBROID POLYP CAUSING ILEAL INTUSSUSCEPTION. A CASE REPORT

G.M. DE LUCA*, P. VENEZIA, C. LORUSSO, I. CONVERTI, C. COVELLI, M. CARELLA, E. D'AMBROSIO, A. FIORELLA, R.M. ISERNIA, M. TESTINI

Dipartimento di Scienze Biomediche ed Oncologia Umana, Unità Operativa Dipartimentale di Chirurgia Endocrina, Digestiva e d'Urgenza, Università degli Studi di Bari "Aldo Moro", Bari, Italia
Dipartimento di Anatomia Patologica, Università degli Studi di Bari "Aldo Moro", Bari, Italia
Dipartimento per le Applicazioni in Chirurgia delle Tecnologie Innovative, Unità Operativa Complessa di Chirurgia Plastica e Ricostruttiva, Università degli Studi di Bari "Aldo Moro", Bari, Italia

Objective: Inflammatory fibroid polyp (IFP) is a rare benign submucosal lesion localized most commonly in the gastric antrum or less frequently in the ileum. Intussusception due to IFP is a rare cause of intestinal obstruction.
Methods: An 85-year-old man was admitted to our Academic Institution 4 days after the onset of an intestinal obstruction, showing anorexia, nausea, bilious vomiting and abdominal pain. The CT-scan showed a 7 cm ileum stenosis with intussusception and signs of intestinal obstruction, associated with hyperdensity of perivisceral adipose tissue and vascular anomalies. Emergency laparotomy confirmed the radiological findings and an ileal resection with mechanical side-to-side anastomosis was performed.
Results: The recovery was uneventful and the patient was discharged in 10th day. A histological examination revealed an IFP, confirmed by immunohistochemical findings.
Conclusions: Intussusception observed frequently in children but is rare in adults representing the cause of approximately 1% of bowel obstructions and is frequently associated with neoplasm, malignant or otherwise. The most frequent type of intussusception is one in which the ileum enters the cecum, however other types that are known to occur, such as when a part of the ileum or jejunum prolapses into itself. Benign etiology includes parasite, Meckel's diverticula, ileum fibroma, previous surgery, ileal and jejunal polyp.
A rare huge IFP can cause small bowel intussusception. Emergency surgery is the treatment of choice.

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SPONTANEOUS MESENTERIC HAEMATOMA IN AN INFLAMMATORY EXACERBATION OF CROHN'S DISEASE

J. MANFIELD*, M. VENZA, ASHRAFIAN HUTAN, MATHUR PAWAN

Department of Surgery and Cancer, Imperial College London, London, United Kingdom
Barnet and Chase Farm Hospitals, NHS Trust/ UCL Medical School, London, United Kingdom
Department of Surgery, Università Tor Vergata, Rome, Italy

Objective: Spontaneous mesenteric haematomas (SMH) result from localized bleeding in the mesenteric vascular bed of a bowel segment without demonstrable cause and are rarely encountered. We describe the first case of SMH in a patient with Crohn's disease.
Methods: Case report, review of the literature and discussion.
Results: A forty-four-year-old female patient was admitted with an exacerbation of Crohn's disease. Abdominal symptoms were suggestive of intestinal stenosis and worsened despite intensification of medical therapy (corticosteroids and azathioprine). Computed tomography (CT) identified a terminal ileal stricture, and a distinct large inflammatory phlegmon or haematoma in the left mid-abdomen. Following non-resolution of small bowel obstruction, a laparotomy was performed for bowel-sparing resection and primary anastomosis. A concomitant mid-jejunal SMH (9x12x20cm) that corresponded to the mass on CT was identified and managed conservatively. There was no evidence of mesenteric vascular root pathology or active mesenteric vessel haemorrhage. Post-operative recovery was uneventful.
Conclusions: Bowel mesentery is increasingly understood as a substantial source of inflammation in Crohn's disease and its association with SMH may reveal a novel mechanistic association between inflammatory bowel disease and microvasculature pathology. This case emphases the unpredictability of SMH and demonstrates the efficacy of conservative management in appropriate cases where there is no evidence of active bleeding.

PNEUMOMEDIASTINUM AS AN UNUSUAL MANIFESTATION OF ACUTE COLONIC DIVERTICULITIS

G. PATANIA*, A. VAGLIASINDI, C. BENINI, M. NEGRI, S. BOLZON, U. GRANDI, P. SOLIANI

U.O. chirurgia generale e d'urgenza, S.Maria delle Croci Ravenna, Ravenna, Italia
U.O. chirurgia generale e d'urgenza-Scuola di Specializzazione in Chirurgia Generale, S. Maria delle Croci Ravenna-Università di Catania, Ravenna, Italia

Objective: Perforation is a tipical complication of colonic diverticulosis. Clinical signs of peritoneal irritation may be evident in cases of intra-peritoneal free perforation, but may be hidden in cases of retroperitoneal perforation. The atypical manifestation of retroperitoneal diverticular perforation can cause diagnostical difficulties.
Methods: A 72 old woman presented with abdominal pain. The abdomen was slightly distended and tender over the lower abdomen, without signs of generalized peritoneal irritation. Two hours later hyperpyrexia occurred; so we performed chest x-ray that showed pneumomediastinum in patient with clinical history of giant hiatal hernia.We integrated with a chest-abdomen-pelvic CT scan that showed considerable pneumomediastinum, associated to a free air in the endo-peritoneal and retro-peritoneal compartment; and a large number of diverticular protusions at sigma. We decide for a conservative management. 24 hours later it occurred clear worsening of objectivity abdominal appearance with clinical signs of acute generalized peritonitis, low blood pressure, urine output contraction. We decided for a surgical treatment. The surgical exploration showed: acute perforated diverticulitis of the sigmoid colon, widespread diverticulosis of the transverse colon, massive retroperitoneal abscess involving the pre- aortic and left retro- renal space.
Results: We performed a Hartmann's procedure, associated to a drainage of massive retroperitoneal abscess, and left annessiectomy. We closed the abdominal wall by the interposition of VICRIL mesh, just to avoid the compartimental intra-abdominal sindrome. Postoperative period was uneventful**.**
Conclusions: Pneumomediastinum related to retroperitoneal diverticular perforation is an unusual clinical manifestation.

** Presenting Author*

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LAPAROSCOPY FOR SMALL BOWEL OBSTRUCTION, SINGLE CENTRE EXPERIENCE

S. COLLURA*, N. VETTORETTO, M. GIOVANNETTI

Chirurgia Generale, Opedale "M. Mellini", Chiari (BS), Italia, Terza Divisione Chirurgia Generale, Clinica Chirurgica, Spedali Civili Brescia, Università di Brescia, Brescia, Italia

Objective: To evaluate the results of laparoscopy for SBO (small bowel obstruction) in our initial experience and to understand if this kind of approach, suitable for selected emergencies, is advisable and more successful in selected groups of patients.
Methods: A series of 27 patients has undergone laparoscopic approach since 2000 in our hospital out of a total of 215 operations for small bowel obstruction. All of them underwent plain films of the abdomen prior to surgery, whereas a CT-scan was performed for 13 of them. Entry was performed in every case in "open" fashion away from previous scars. Multiple or midline incisions and free fluid were not exclusion criteria for laparoscopy. 8 of them had a previous midline laparotomy, while 14 had a Mc-Burney incision.
Results: Overall conversion rate was 37% (10/27), every time to laparoscopy-guided mini-laparotomy. Mean operative time 84 minutes (range30'-241'). 5 of the 10 conversions interested patients with previous midline scar and in the other five cases there was a Mc-Burney incision. For all the patients with no other previous abdominal surgery the intervention was completed laparoscopically. In 8 out of 10 cases the conversion was due to the need of small bowel's resection. The presence of a single band seems not to be important in our series.
Conclusions: Pre-operative selection of the patients is unsatisfactory in our case series. Intraoperative selection is more reliable after explorative laparoscopy. The need for conversion in absence of bowel ischemia is low (10,5%).

A RARE CASE OF SMALL BOWEL ADENOCARCINOMA, PRESENTING WITH INTESTINAL SUBOSTRUCTION: CASE REPORT AND LITERATURE REVIEW

A. ZULLO*, C. FOLLIERO, D. DIGNITOSO, R.L. CONGIUSTA, R. ROMANO, R. CARDONA, R. SACCO

UMG-Università Magna Graecia Catanzaro, Policlinico universitario Germaneto, Catanzaro, Italia

Objective: Small bowel malignant tumors are uncommon malignant neoplasms accounting for only 3% of all gastrointestinal malignancies. Small bowel adenocarcinomas (SBAs) is rare in comparison with other gastrointestinal malignancies but its incidence is rising (35-50%).
Methods: We report a case of a 53-years-old man, with adenomatous polyposis, who presented remitting abdominal pang (sharp pain) associated with loss of weight, vomit and diarrhea. These symptoms made worse until to present sub bowel obstruction confirmed by abdominal-Rx and TC. Therefore, we decided to underwent the patient to open surgery. During surgery we have reported a jejunum stenosis, so we have performed an jejunum-ileum resection and an omental biopsy. The istological exam resulted positive for small bowel adenocarcinoma without lymphonodal metastasis but an omental metastasis. To complete the diagnostic-terapeutic iter we submit the patient to a TC total-body, which has resulted negative for secondarism, and then, we proposed to the patient a new surgery to remove omento, appendix and gallbladder, resulted free by desease. Actually the patient is out of desease.
Results: Usually, SBA is most commonly located in the duodenum (55%), followed by the jejunum (30%) and the ileum (15%). It often presents at an advanced stage due to the non-specific symptomatology, in fact diagnosis of SBA is usually made at an advanced stage (74% stage III or IV).
Conclusions: The treatment of SBA is surgery with an overall rate of curative resection of 40–65%. The role of adjuvant chemotherapy is not well defined.

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GASTRIC BLEEDING REFRACTORY TO ENDOSCOPIC TREATMENT: A GUIDE SELECTIVE EMBOLIZATION

S. GIUNGATO*, M. CARELLA, G. DI MEO, E. D'AMBROSIO, V. FERRARO, A. GIRARDI, G. PICCINNI, M. TESTINI

Dipartimento di Scienze Biomediche ed Oncologia Umana, Unità Operativa Dipartimentale di Chirurgia Endocrina, Digestiva e d'Urgenza, Università degli Studi di Bari "Aldo Moro", Bari, Italia

Objective: There are some cases of gastric bleeding refractory to endoscopic treatment. In these cases transcatheter arterial embolization (TAE) of the target vessel is indicated . We propose to pose a pair of endoscopic hemoclips to localize the exact position of bleeding lesion at angiography to obtain an accurate and quick haemostasis with TAE.
Methods: In 10 patients with acute bleeding, an endoscopic treatment was performed for stopping the haemorrhage. When the bleeding was not controlled, one or two metallic clips were left in place to mark the area. In 6 patients, TAE was indicated as a result of continued or recurrent bleeding. In 2 patients, angiography revealed that there was no indication for TAE, but the marking clip was still in place. In the last 2 patients a recurrence of bleeding after 48 hours lead to the performance of TAE to close the artery afferent to the clip.
Results: In all patients the clips were still in place at angiography. Haemostasis was achieved in 6 patients after TAE. In 2 patients the clips were essential to identify the bleeding vessel.
Conclusions: Marking a bleeding ulcer with a clip before TAE makes the selective closure of the liable vessel simpler. This strategy offers the opportunity to embolize the right target in a fast and precise fashion.

* *Presenting Author*