

Video High Quality

V25 - Esophagus, Stomach, Livers: Tumours

A NEW LAPAROSCOPIC METHOD FOR GIANT MYOMA RETRIEVAL

M. Berberoglu, B. A. Aydin, F. Ercan, F. Balaban

*ITEM, Advanced Medical Technologies and Training Center

Background: The use of laparoscopic surgery for myomectomy is still controversial. The removal of those fibroids which are suitable for relatively simple laparoscopic techniques may not be necessary. Those requiring removal by virtue of their size. Removal of the fibroid from the abdomen may present a problem if it is greater than 2-3 cm. in diameter. The trocar incision may be enlarged, a cruciate incision in the floor of the pouch of Douglas may be used or the fibroid may be morcellated with a tissue punch. Although a more effective way is to enlarge one of the abdominal incisions, **Method:** We made incise the superficial peritoneum and possibly the myoma with monopolar electrode in a midline longitudinal plane. The dissection plane for enucleating the myoma should be identified. Traction may be applied to the edge of the myoma with 10 mm. endoscopic myoma driller, in order to free the myoma completely with sharp dissection and coagulate vessels with bipolar forceps. The myoma pedicle can be coagulated with bipolar forceps. After sectioning the base of the myoma, its edges. Coagulation of the bed and the edges were required suturing with extracorporeal knots. The fibroid than can be cut in pieces under laparoscopic visual control using a surgical blade. Blades can be attached to the tips of the laparoscopic grasping forceps. Scalped must be reinforced by using no:0 silk thread to achieve the immobility. After this treatment, a lot of pieces of fibroids may be picked up and removed from abdomen with grasper forceps.

Conclusion: This method is fast, easy and remarkably safe when comparing with the monopolar slicing of the myomas.

V26 - From Chin to Pubis

LAPAROSCOPIC LIVING DONOR NEPHRECTOMY OUR EXPERIENCE.

A. Pietrabissa, U. Boggi, C. Moretto, F. Vistoli, M. Ghilli, F. Mosca
Divisione di Chirurgia Generale e Trapianti, Dip. di Oncologia, dei Trapianti e delle Nuove Tecnologie in Medicina, Università di Pisa - Pisa, Italy

Laparoscopic living donor nephrectomy has been introduced in Pisa (Italy) in April 2000; since to now we have successfully brought five donor nephrectomies.

After inducing a 12 mmHg pneumoperitoneum, the surgeon starts the left nephrectomy with 3 trocars technique; left colon is medially upset. The Gerota's fascia is exposed and the upper pole is completely freed. After the exposition of the renal vein, the gonadal, adrenal and lumbar veins are sectioned applying titanium hemoclips. The renal artery is identified behind the vein. It is our practice, in this as in many other circumstances, to make a suprapubic transverse 6/7 cm skin incision. The bag is introduced through this incision without loss of pneumoperitoneum and opened in hypocondrium. After urethral dissection up to the cross of the iliac vessels, a GIA stapler is used to transect the gonadal vessels and then the ureter is dissected. The remaining renal attachments are divided and the organs (kidney, still connected to the donor, and ureter) are introduced in the endocatch (pre-load); now the donor is given 3000 U of heparin. The camera passes in the left lateral port while a first endovascular GIA stapler (35 mm) is used to cut the artery; the warm ischemia time starts. A second stapler (35 mm) is used to divide the renal vein. The kidney, preloaded in the bag, is now drawn out through the Pfannenstiel incision. Two are the key-points in our method, the preload of the kidney and the use of two preloaded staplers, which allow us to obtain a short warm ischemia time and, consequently, an immediate functional resumption of the kidney.

V27 - From Chin to Pubis

LAPAROSCOPIC DONOR NEPHRECTOMY WITH RETRO-AORTIC LEFT RENAL VEIN

A. Kaul,

New York Medical College, Valhalla, N.Y., BRONX, NY United States of America

Renal vascular anomalies are often found and their presence often complicates minimally invasive procedures done on kidneys. The purpose of this video is to show a case of laparoscopic donor nephrectomy done on a patient with an oblique retro-aortic left renal vein and an accessory renal artery draining the superior pole.

In this video we have shown the role of CT scan with three-dimensional reconstruction for better delineation of the anatomy. The presence of the characteristic long left adrenal vein is highlighted along with the typical position of the renal artery just below the adrenal vein. Steps in dissection of the renal hilum including ways to approach the multiple lumbar veins are also shown. We also show the use of an extraction bag along with our method to deploy it. Our technique of using ultrasonic energy as well as different steps of the procedure are also highlighted.

Retro aortic renal vein is an uncommon anatomical variation but should not be a contraindication for laparoscopic donor nephrectomy. In fact, as this case demonstrates, it may facilitate hilar dissection and allow a longer segment of renal vein to be harvested.

V28 - From Chin to Pubis

HAND-ASSISTED LAPAROSCOPIC DISSECTION OF THE LIVER HILUS IN LIVER RESECTION. A STEP TOWARDS LAPAROSCOPIC OPERATIONS FOR LIVING DONOR LIVER TRANSPLANTATION?

D. Arvidsson, U. Jersenius, A. Rosseland, A. Waage
Department of Surgery, Karolinska Hospital, Stockholm

Aim: This video demonstrates how to perform a laparoscopic dissection in the liver hilus using the extra-Glissonian approach as described by Launois.

Methods: A hand-assisted technique is used to dissect and isolate the pedicles to the right and left lobe. Then, either a further dissection can be performed to isolate segments 5-8 or a dissection within the capsule to reach the right portal vein and bile ducts. The latter approach would be most suitable for living donor operations using the right lobe since blood flow to the left lobe could temporarily be occluded and the resection line demarcated.

Results: The video shows the above described technique.

Conclusion: Laparoscopic liver resection is slowly evolving. Living donor transplantation might be a future indication.