Society of Surgeons Trinidad & Tobago

AMERICAN COLLEGE OF SURGEONS
Trinidad and Tobago Chapter

In Conjunction with

The University of the West Indies

THE SOCIETY OF SURGEONS OF TRINIDAD & TOBAGO NATIONAL GRAND ROUNDS 2021

SUNDAY NOVEMBER 14TH 2021

@8AM

A VIRTUAL MEETING VIA ZOOM

https://uwi.zoom.us/j/91951645402

Website: www.sott.org Twitter: @surgeonstt Email: surgeonssociety@gmail.com

1)

TITLE: Abrikossoff Tumor Mimicking Carcinoma in Accessory Axillary Breast Tissue.

PRESENTER: Lyronne Olivier

AUTHOR(S): Lyronne Olivier, Dale Hassranah, Vijay Naraynsingh.
Department of General Surgery, Sangre Grande Hospital, Sangre Grande, Trinidad and Tobago

CONTACT: lyrokel@hotmail.com

SPECIALTY: Breast Surgery/ General Surgery

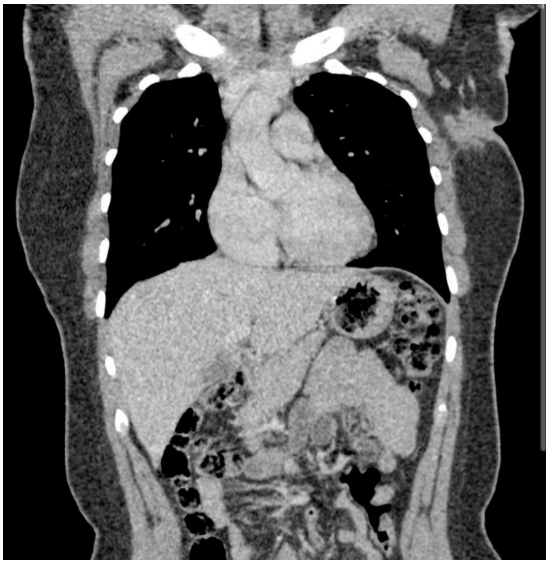
ABSTRACT:

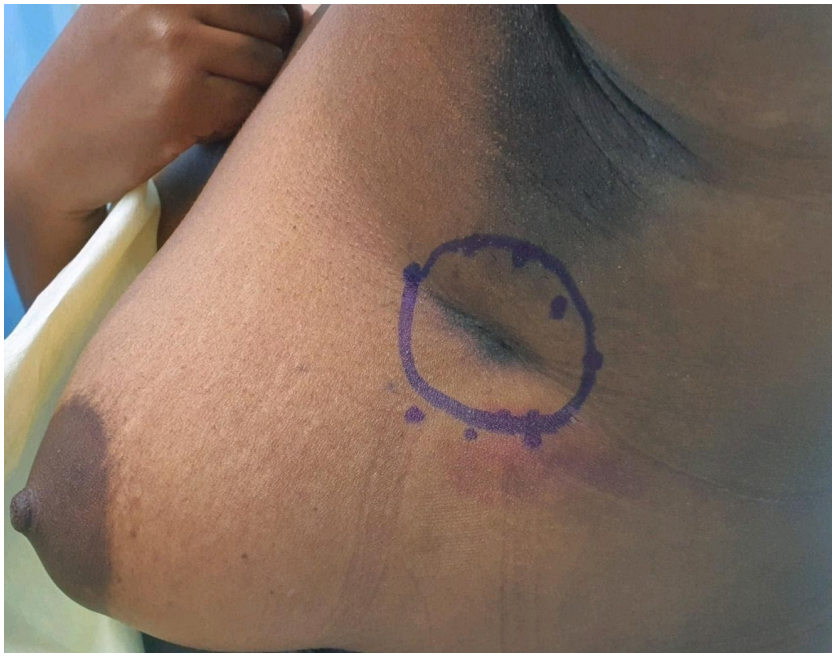
Introduction: Abrikossoff tumors are rare benign soft tissue lesions also known as Granular Cell Tumors (GCT). The histogenesis of these tumors was initially considered to be myogenic but recent studies have revealed a neuroectodermal origin. GCTs of the breast may mimic breast carcinoma based on the triad of radiological, clinical and pathological features. This hallmark trait lends to the misdiagnosis of these tumors and its subsequent inappropriate management.

Case Description: We report the rare case of a 28-year old female patient with an accessory axillary breast GCT with clinical features suspicious for underlying malignancy.

Discussion: The diagnosis, histogenesis and the management of Abrikossoff tumors of the breast are discussed .

Question
What are Abrikossoff tumors of the breast and how do they mimic breast cancer ?





2)

TITLE: Case report of metastatic breast cancer mimicking ileal Crohn's disease

PRESENTER: Sandeep Maharajh
Department of Surgery, Medical Associates Hospital, Trinidad and Tobago,

AUTHORS: Sandeep Maharajh, Vijay Naraynsingh

CONTACT: sk_maharajh@hotmail.com

SPECIALTY: General Surgery

ABSTRACT:

Introduction: Lobular breast cancer (LBC) has an increased risk of gastrointestinal (GI) spread compared with ductal breast carcinoma. Breast cancer commonly metastasises to bone, lung, liver, central nervous system and rarely to the gastrointestinal tract. As the prognosis for breast cancer continues to improve with modern medical practice it is important to be aware of the various clinical presentations and the appropriate management of breast cancer metastases.

Case Description: We describe a case of a 60-year-old woman who presented with symptoms of bowel obstruction 30 months after undergoing mastectomy and adjuvant chemotherapy for LBC. A Computer Tomography (CT) scan showed terminal ileal thickening suggestive of Crohn's disease but histopathology revealed metastatic lobular carcinoma. Surgical resection to relieve her small bowel obstruction confirmed LBC.

Discussion: Is ileal Crohn's disease in a patient with breast cancer a 'safe' diagnosis? Is there a reliable way of distinguishing between these two diagnoses preoperatively? This case illustrates an unusual presentation of metastatic breast cancer causing small bowel obstruction with radiological features mimicking Crohn's disease. Patients with breast cancer can present with intestinal obstruction due to metastatic spread to the small intestine; this may resemble Crohn's disease clinically and radiologically.

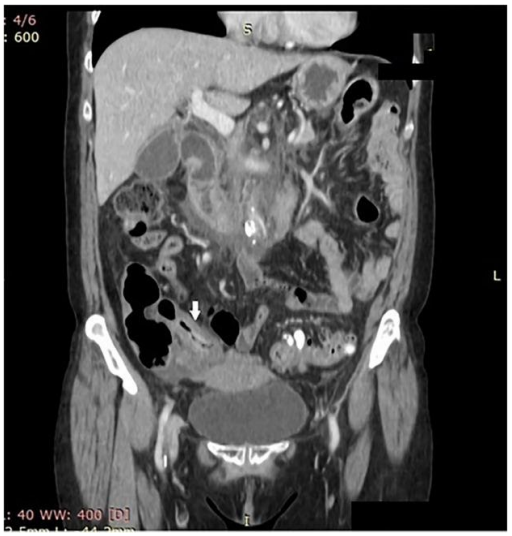


Fig 1. Thickened ileum mimicking Crohn's disease (arrow)

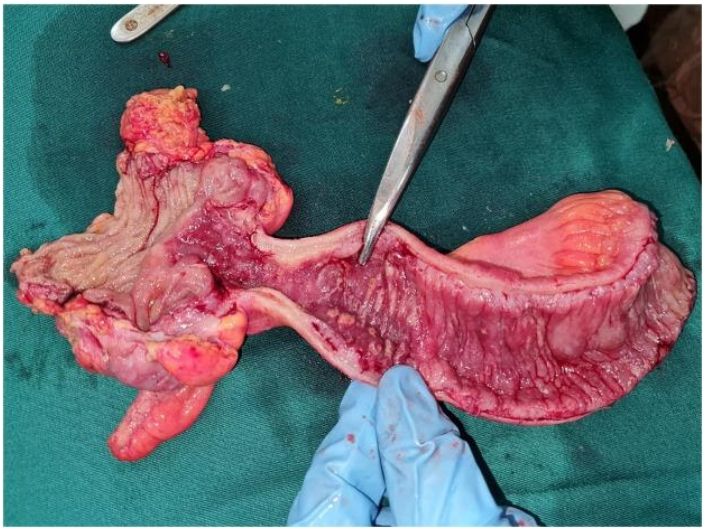


Fig. 2 The obstructing lesion in the ileum

3)

TITLE: A Case of gas gangrene superimposed on breast carcinoma

PRESENTER: Dr. Avidesh H. Mahabir[1]

AUTHORS: Dr. Avidesh H. Mahabir[1], Dr. Shariful Islam[1], Dr. Aneela Shah[1]
Department of Surgery, San Fernando General Hospital, South-West Regional Health Authority

CONTACT: avideshmahabir0@gmail.com

SPECIALTY: Breast/ General Surgery

ABSTRACT:

Introduction: Gas gangrene of the breast is a clinical entity infrequently described in surgical practice and like other necrotizing soft tissues infections (NSTIs), occurs due to localised trauma and often in immunocompromised patients.

We present a case of a breast cancer patient with gas gangrene of the ipsilateral breast, who underwent emergency radical mastectomy with delayed primary closure.

We seek to discuss the incidence of this rare pathology, its associated microbiology and the options for surgical management.

Case description: A 60-year-old female with locally advance right breast cancer, poorly responding to neoadjuvant chemotherapy, presented with a 'ruptured right breast'. On assessment she had clinical and radiological evidence of gas gangrene of the breast with systemic signs of sepsis. She underwent emergency radical mastectomy with delayed primary closure. The single causative organism based on tissue culture was *Escherichia coli.* She had an uneventful postoperative recovery and was discharged for outpatient care.

Discussion: Gas gangrene is classified as traumatic or spontaneous with the more common organism being *Clostridium perfringens* or *Clostridium septicum* respectively. It commonly occurs in regions like the genitalia, abdominal wall or extremities bit rarely the breast. Our case examines the uniqueness of this presentation and discusses the options for surgical management, including radical versus simple mastectomy in the emergency setting.

4)

TITLE: Late Neck Metastases of Locally Controlled Right Auricular Skin Malignant Melanoma

PRESENTER: Shivanni De Gannes

AUTHORS: Shivanni De Gannes, Rickhi Ramoutar, Rodolfo Arozarena Fundora, Solaiman Juman
Department of Surgery, EWMSC

CONTACT: shivanni.degannes@outlook.com/

SPECIALTY: Otorhinolaryngology

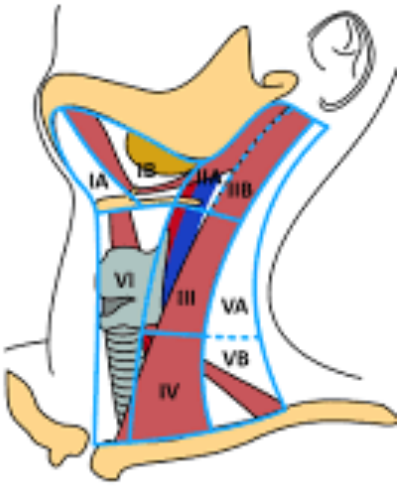
ABSTRACT:

Melanoma is a malignant transformation of melanocytes and is considered a neural crest neoplasia. While it represents only 5% of all cutaneous malignancies, it is responsible for the vast majority of skin cancer-related deaths. There has been a recent, progressive increase in the worldwide incidence, with the highest rate noted among the white population. Head and Neck Melanomas represent approximately 20% of melanoma when anatomical distribution is described.

We present a case of a 66-year-old Caucasian male with right neck metastases from cutaneous auricular melanoma 4 years prior and a history of multiple surgical procedures for cutaneous lesions.

He presented with a 3 months history of a right-sided neck mass that started at the angle of the mandible and progressively increased in size, with no tenderness, overlying skin changes or discharge. Of note, his most recent procedure was for a right auricular malignant melanoma excised 4 years prior and at time of presentation there were no new cutaneous lesions. Physical examination found a right-sided neck mass in levels II and III. Computed Tomography (CT) of the Head and Neck showed multiple masses in levels I to III, suspicious for metastases. The patient was clinically staged as Metastatic Malignant Melanoma of Stage IIIb using the AJCC TNM staging.

The patient was reviewed with the Plastic Surgical Team for soft tissue reconstruction as needed. Surgical intervention with a right extended radical neck dissection including the right parotid (with Facial Nerve preservation) and pre and post auricular lymph nodes was performed. Chemotherapy and Radiotherapy followed after achieving surgical control. Why was this management chosen?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5)

TITLE: Ancient cervical vagal schwannoma and an interposition great auricular to vagus nerve graft

PRESENTER: Jibran Juman

AUTHORS: Jibran Juman/Nicholas Figaro/ Rodolpho Arozarena Fundora / Solaiman Juman
Department of Surgery,
Eric Williams Medical Sciences Complex,
Mt Hope,

CONTACT: jibran.sjuman@gmail.com

SPECIALTY: Otorhinolaryngology

ABSTRACT:

Schwannomas also known as neurilemmomas are benign neoplasms derived from myelinated Schwann cells. These nerve sheath tumors can occur throughout the body, with approximately one-third found in the head and neck region in individuals between the ages of thirty (30) and sixty (60). Schwannomas of the cervical vagus nerve are exceedingly rare and have a myriad of clinical presentations depending on the tumor size and its proximity to neurovascular structures.

We report a rare case of a cervical vagal schwannoma that was successfully treated with en bloc resection and reconstruction with a great auricular to vagus nerve graft.

A forty-two (42) year-old male presented with a two (2) year history an asymptomatic, gradually expanding, right lateral neck mass. Magnetic resonance imaging revealed a lesion 2.4 cm × 1.4 cm × 4.0 cm in size, located between the carotid arteries and internal jugular vein displacing the internal carotid artery anteromedially.

The treatment of choice for a vagal schwannoma is complete surgical excision with preservation of the neural continuity. However, due to the intimate relationship shared with the vagal nerve fibers and the tumor capsule in our case, a safe surgical plane could not have been identified. As a result, an en bloc resection of the lesion with nerve sacrifice was performed, with reconstruction of the vagus nerve with a great auricular interposition graft.

6)

TITLE: The cytokine storm; a floating thrombus of the Internal Carotid Artery successfully treated medically, in the setting of Covid-19 infection.

PRESENTER: K A Bobb

AUTHORS: K A Bobb ,D Harnanan, L Pran, V Naraynsingh
Department of Surgery, Eric Williams Medical Sciences Complex

CONTACT: kellyabobb@gmail.com

SPECIALTY: Vascular Surgery Eric Williams Medical Science Complex

ABSTRACT:

Introduction: Since the onset of the novel Corona virus pandemic, intra-vascular and intra-arterial thrombosis has become an area of concern, with arterial thrombosis occurring in 3.7% of cases.

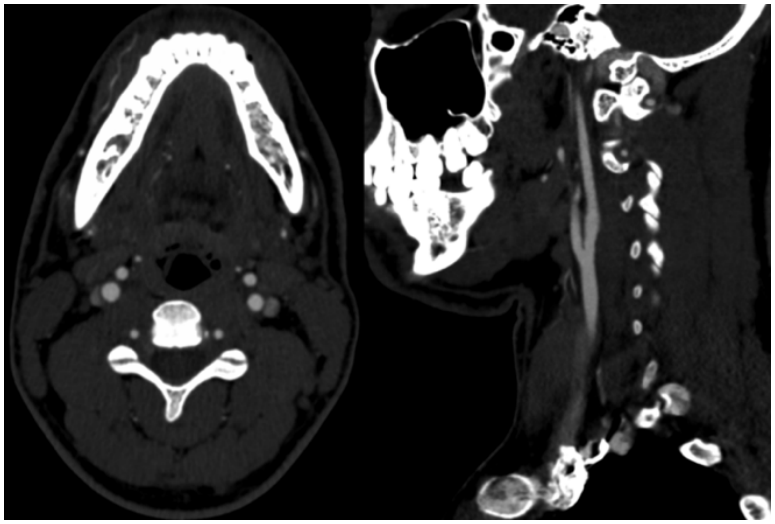
Case: A 24-year-old male type-2 diabetic and COVID-19 positive, presented with right sided facial droop, dysarthria, dizziness, confusion and personality changes. Neurological exam noted 4/5 power in the right upper limb with no other neurological deficits. A trans-thoracic echocardiogram and ECG ruled out cardio-embolic causes.

CT brain revealed acute left frontal and parietal infarcts. Bilateral carotid duplex scans indicated a left proximal internal carotid artery (ICA), mobile intraluminal thrombus causing >45% stenosis, which was correlated by CT angiogram.

At a multidisciplinary meeting, it was decided that the patient would be best managed medically (anticoagulation and antiplatelet therapy). There was resolution of neurological symptoms, and repeat CT angiogram of the carotid vessels 5 days after starting anticoagulation demonstrated complete resolution of the left ICA thrombus. At follow-up 12 weeks later, he had no recurrent episodes and on carotid duplex there was no abnormality of the left CCA or ICA.

Discussion: This case highlights the risk of vascular compromise in Covid-19 cases due to the hypercoagulable state and endothelial dysfunction associated with this disease process. The patients age, and lack of vascular risk factors, further strengthens the concept of COVID-19 as an endothelial disease.

Conclusion: The association between Covid-19 and stroke has been established. However, the data is not robust enough to guide clinical practice and clinicians should determine management based on individual cases.



7)

TITLE: Spontaneous Pneumomediastinum associated with Covid -19 pneumonia, the Macklin effect.

PRESENTER: K A Bobb

AUTHORS: M West, K A Bobb, C Calderon, A Rampersad
Eric Williams Medical Science Complex, Couva Medical & Multi-Training Facility

CONTACT: kellyabobb@gmail.com

SPECIALTY: Cardiothoracic Surgery

ABSTRACT:

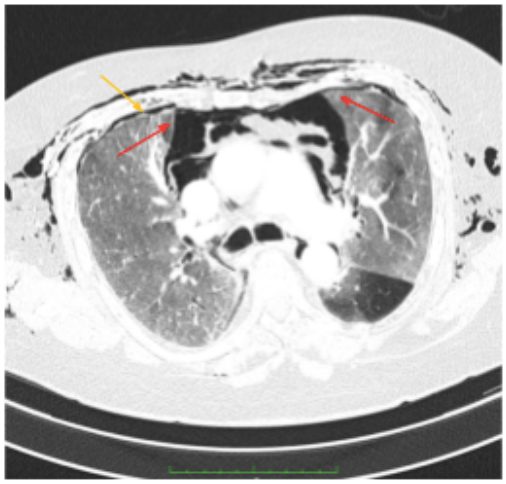
Introduction: Spontaneous pneumomediastinum (SP) is a rare complication of SARS-CoV-2 infection, of unknown definitive etiology; which has increased in incidence with the Covid-19 pandemic.

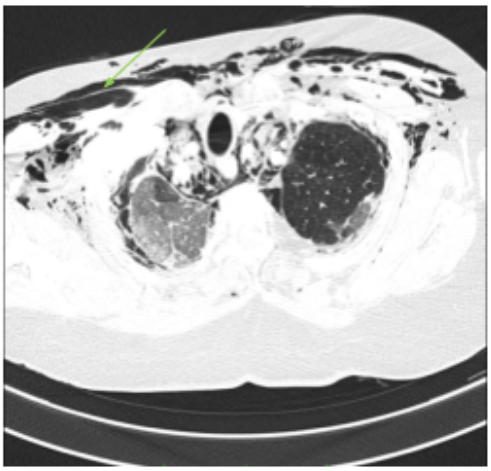
Case: A 63-year-old female, known asthmatic, presented with a complaint of worsening shortness of breath and an associated dry cough. She was tachypneic at 24 cycles/min with an oxygen saturation at 95% with supplemental oxygen. Her chest X-ray (CXR) was remarkable for bilateral patchy infiltrates. No other pathologies were noted. Lab investigations depicted a white cell count of 2320 cells/µL and a CRP at 176 mg/dL.

On day 2 of admission, a computed tomography (CT) pulmonary angiogram was ordered, objectifying a CT severity score of 20/25, tense pneumomediastinum and bilateral pneumothoraxes. The patient was reviewed by the cardiothoracic and intensive care team, and a decision was made to manage this rare complication with placement of bilateral chest tubes, and non-invasive continuous positive airway pressure (CPAP).

Discussion: This case highlighted an uncommon complication of viral pneumonia, which is being documented internationally with increasing incidence in association with the novel coronavirus (covid-19). A possible mechanism of SP is linked to the degree of alveolar damage that can occur in severe pneumonia.

Conclusion: The development of SP is correlated with severe and worsening viral pneumonia. Management options vary and is dependent on the presence of a tension pneumomediastinum. Fortunately, most of these cases can be managed non-surgically.





8)

TITLE: Incomplete Pentalogy of Cantrell - A Case report

PRESENTER: Arvind Seecharan

AUTHORS: Arvind Seecharan, Mr. Barrie Landreth-Smith
Paediatric Surgery Department, Eric Williams Medical Sciences Complex, Trinidad and Tobago

CONTACT: arvindseecharan@gmail.com

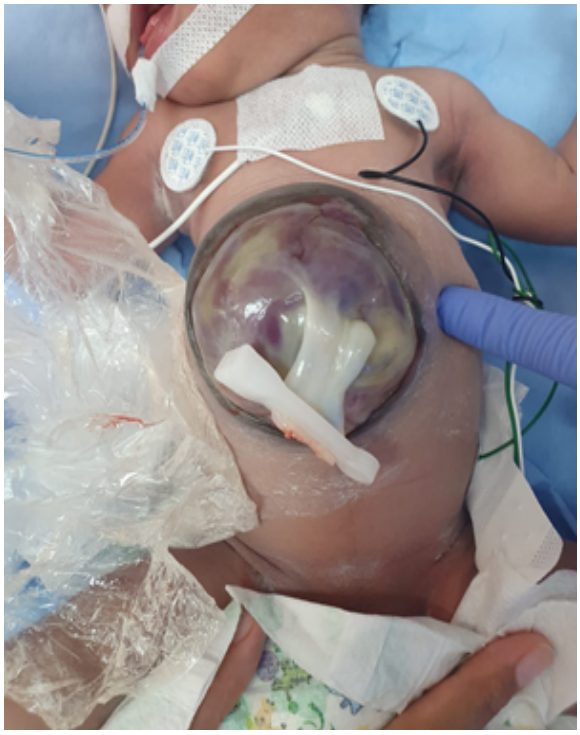
SPECIALTY: Paediatric Surgery

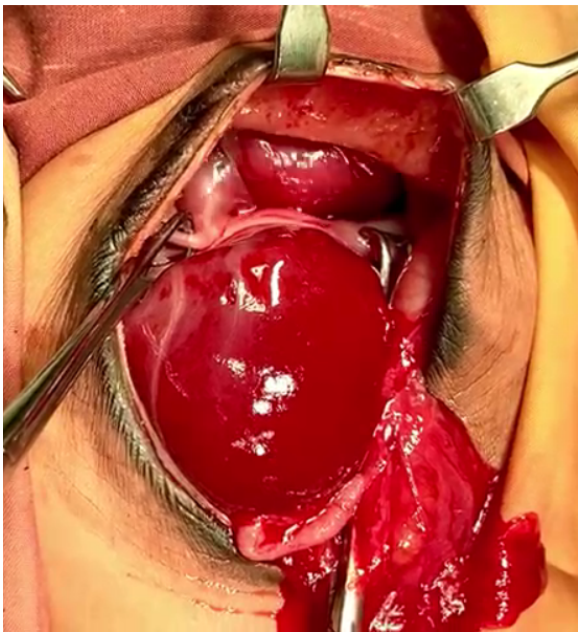
ABSTRACT:

Introduction: Pentalogy of Cantrell is a rare, congenital disorder characterized by midline supraumbilical abdominal defect, defect of the lower sternum, deficiency of the diaphragmatic pericardium, deficiency of the anterior diaphragm, and congenital cardiac abnormalities. The condition is classified as a definite diagnosis or as complete or incomplete based on the number of malformations present.

Case Description: We present a rare case of a male neonate born with incomplete Pentalogy of Cantrell. This infant was born at 37/40 to a 26-year-old G4 P4+4 mother, weighing 2935g. He was diagnosed as Omphalocele Major, with multiple cardiac defects, and dysmorphic features. Prior to repair of the omphalocele major, this patient was assessed to have a congenital diaphragmatic hernia with ectopia cordis. He underwent a primary repair of the omphalocele major with repair of the congenital diaphragmatic hernia on day two of life. He was subsequently discharged home with repair of cardiac defects being planned.

Discussion: Multidisciplinary care and pre-operative planning are essential in patients with Pentalogy of Cantrell. Prognosis depends on the type and severity of associated malformations, intra-cardiac anomalies, and on the location of the ectopic heart. Timing of surgical interventions is debated with each case having unique risk-benefit ratios. Stable neonates may benefit from conservative management, allowing epithelialization of the omphalocele sac while critically ill patients require increased supportive care, in turn impacting the timing of surgery.
Would this patient have benefited more from a delayed repair of the congenital abnormalities?





9)

TITLE: A childhood thoracocervical lymphatic malformation.

PRESENTER: Arvind Seecharan

AUTHORS: Mr Barrie Landreth-Smith, Mr Ian Ramnarine, Arvind Seecharan, Cidi Dubay
Surgery Department, Eric Williams Medical Sciences Complex, Trinidad and Tobago

CONTACT: arvindseecharan@gmail.com

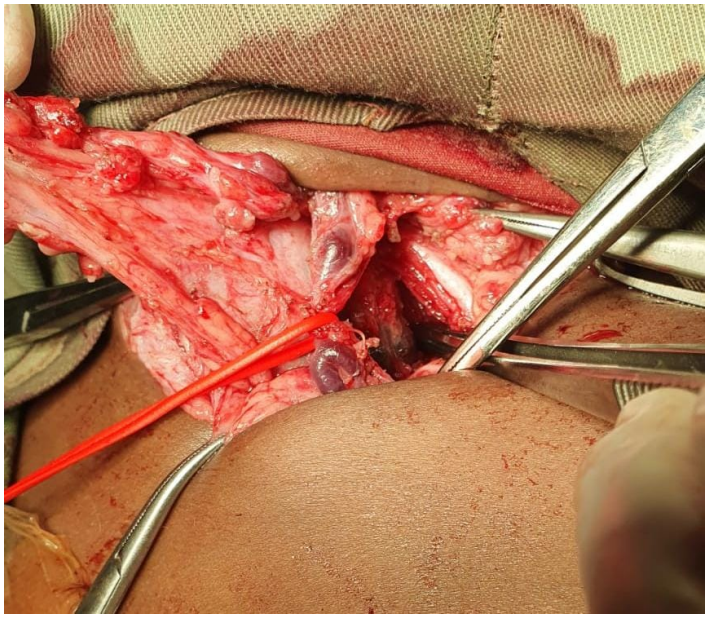
SPECIALTY: Paediatric Surgery, Cardiothoracic Surgery

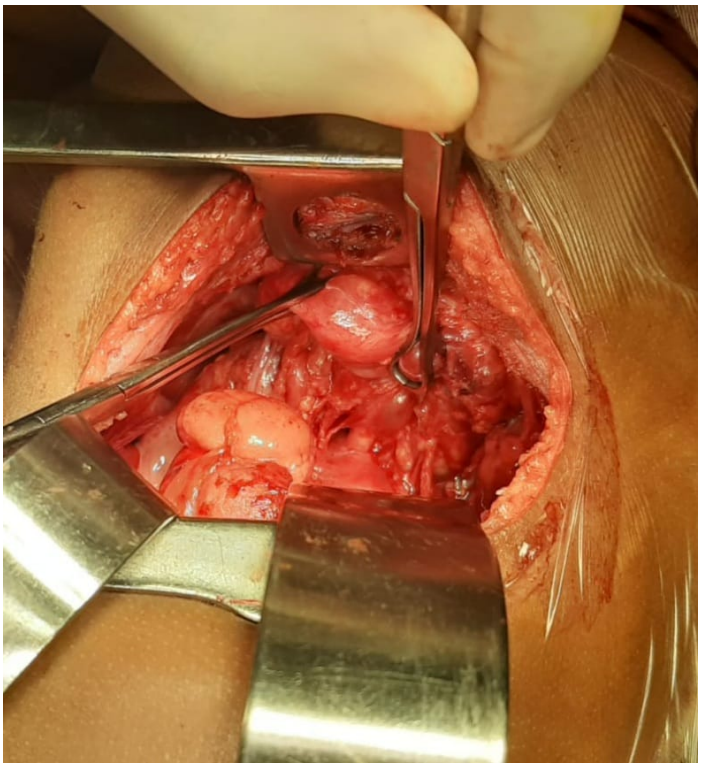
ABSTRACT:

Introduction: Cervical lymphatic malformations in childhood are not unusual. We present our rare tumour in the left neck and chest that was intimately related to the subclavian vessels and major nerves.

Case Description: A two-year-old girl presented with an enlarging left posterior triangle mass. Contrast-enhanced CT showed a mixed solid and cystic lesion extending from the left Cervical region posterior to the carotid sheath and compressing the trachea and oesophagus; through the thoracic inlet and into the posterior mediastinum. It crossed the midline and also caused compression of the trachea and splaying of the great vessels. Both left subclavian vessels ran through the middle of the tumour. A multidisciplinary approach was taken and surgical resection performed by two incisions one in the left neck and the other via left thoracotomy. The tumour had both solid and cystic components and as many vital structures as possible were saved during resection.

Discussion: Several treatment modalities exist for Lymphatic malformations, including watchful waiting, sclerotherapy, radiotherapy and surgical resection. Infection or spontaneous intralesional hemorrhage can lead to sudden expansion and subsequent catastrophic fallout, including airway or cardiopulmonary compromise, and mortality. Our patient already had both clinical and radiological evidence of airway and great vessel compression following a viral illness. Surgical excision involved risk to major, vital neck and intrathoracic structures.
How would you have managed this patient?





10)

TITLE: An interesting case of Vanishing Gastroschisis with in Utero Midgut Strangulation

Presenting Author: Cidi Dubay,

AUTHORS: Cidi Dubay, B Rampersad
Department of Paediatric Surgery, Eric Williams Medical Sciences Complex, Trinidad and Tobago

CONTACT: cididubay@hotmail.com

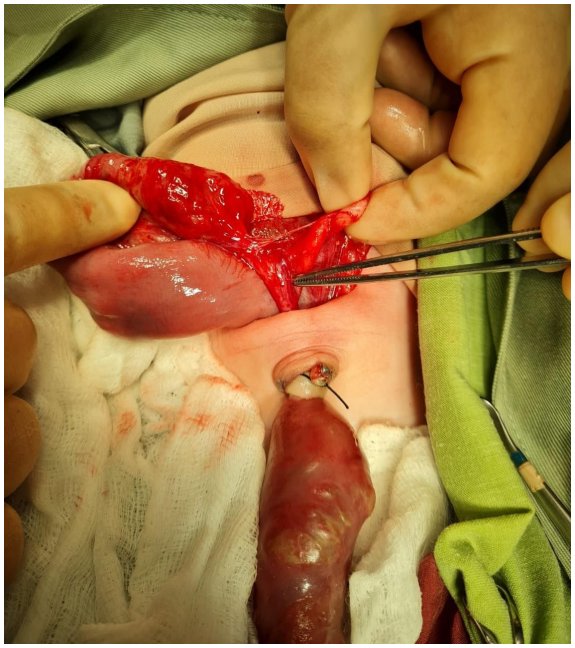
SPECIALTY: Paediatric Surgery

ABSTRACT:

Introduction: Gastroschisis is a congenital ventral abdominal wall defect with subsequent evisceration of intra-abdominal contents. Vanishing gastroschisis is a rare but dreaded complication where closure of the abdominal wall causes strangulation of herniated bowel, with varying degrees of infarction, ischemia or intestinal atresia.

Case Description: An 1856g neonate was delivered at 34 weeks of gestation to a mother with no antenatal care. He was initially referred as an omphalocele. Examination revealed a congested poorly characterized mass (to right of umbilical cord) with a narrow base. Xray showed 2 dilated loops of small bowel with no distal pneumatization. Laparotomy confirmed the presumed diagnosis of vanishing gastroschisis. Unfortunately, there was only 13cm of proximal small bowel, with an atretic blind end. Distally, a patent microcolon was seen re-entering the abdomen from the abdominal wall defect. No salvageable bowel was identified within the extra-abdominal mass. Excision of strangulated mid gut, primary anastomosis (with Cheatle slit to distal limb) and closure of abdominal wall was done. Unfortunately, infant succumbed to line related sepsis several weeks post op.

Discussion: Mortality rate for vanishing gastroschisis is high, and survivors usually face short bowel syndrome with long term parenteral nutrition dependence. Several bowel lengthening strategies exist, such as Bianchi, STEP and LILT procedures, if only as temporizing measures until the child is a candidate for transplant. Severe cases are sometimes managed palliatively. What surgical alternatives were available to us? Was there any way to avoid intestinal failure in this case?



11)

TITLE: Retrograde Intussusception and Giant Meckel's Diverticulum- An Uncommon Encounter

PRESENTER: Fiaz ALI

AUTHORS: Fiaz Al, Lakhan Roop

Department of Paediatric Surgery, San Fernando Teaching Hospital, SWRHA

CONTACT: fiazali@swrha.co.tt

SPECIALTY: Paediatric Surgery,

ABSTRACT:

Introduction: Retrograde intussusception and giant Meckel's diverticulum are both rarely encountered in the paediatric population. We present a case of both conditions encountered in the same infant.

Case Description: A 3-month-old male infant was referred to Paediatric Surgery for progressive vomiting, feeding intolerance and abdominal distension. The child was admitted one day prior by the Paediatricians for viral symptoms and vomiting. The vomiting continued and his abdomen became distended but there was no blood per rectum.

Abdominal radiograph showed features of small bowel obstruction and ultrasonography revealed a 2.1cm X 2.2cm concentric mass within the right upper quadrant representing an intussusception. Pneumatic reduction under ultrasound guidance was attempted once without success, and the patient subsequently underwent a laparotomy.

A 15cm segment of ileo-ileal retrograde intussusception was found at laparotomy along with a proximal giant Meckel's diverticulum with an approximately 10cm base. Manual reduction of the intussusception and wedge resection of the Meckel's diverticulum with ileo-ileal anastomosis was performed.

Discussion: Both retrograde intussusception and giant Meckel's diverticulum are rare entities by themselves. It is extraordinary to encounter both conditions in the same patient, with only one published case report in a child. Such a case brings with it significant diagnostic and management challenges. The retrograde intussusception in our case may have resulted from anti-peristalsis initiated by mild gastrointestinal infection in the ileum. Additionally, wedge resection is a feasible treatment option for giant Meckel's diverticulum. Is there another option?

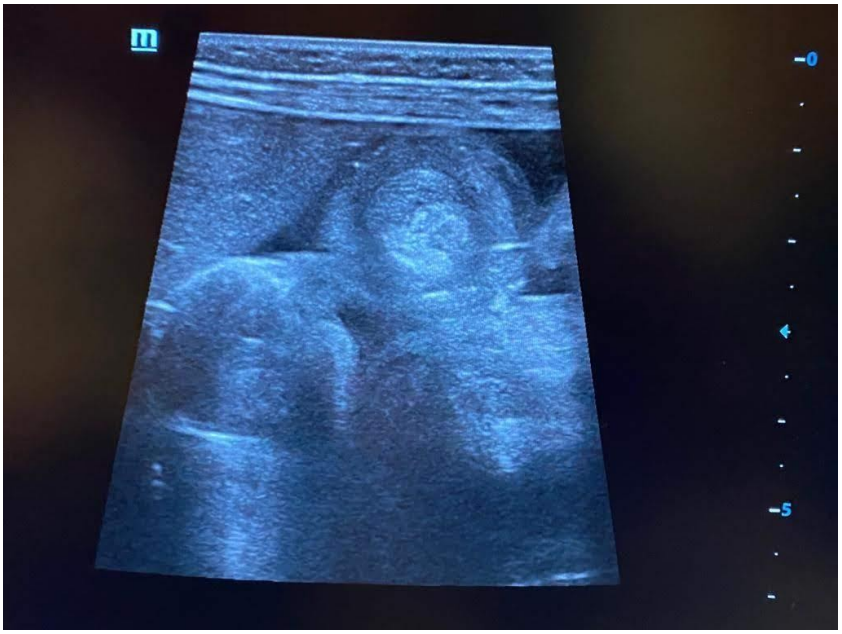


Figure 1: Preoperative ultrasound showing intussusception

12)

TITLE: Congenital Diaphragmatic Hernia- A Teen presentation

PRESENTER: Anisah Khan

AUTHORS: Anisah Khan, Sabrina Labban, Lakhan Roop
Department of Paediatric Surgery
South West Regional Health Authority

CONTACT: sabrinalabban@swrha.co.tt

SPECIALTY: Paediatric Surgery

ABSTRACT:

Introduction: CDH results from abnormal muscularization of the diaphragm during fetal development leading to herniation of abdominal contents into the thoracic cavity with subsequent pulmonary hypoplasia. There are four types, the most common of which is a left sided posterior lateral defect which occurs in 85-90% of CDH patients. Our case is a Morgagni hernia, a subtype of CDH, in which the defect is found in an anterior and retrosternal location.

Case Description: A 13-year-old male, presented to the paediatric medical ward with chicken pox. He seemed to be mostly asymptomatic prior to presentation and on review of symptoms complained of reflux type symptoms. He subsequently had a chest X-ray that showed an abnormal pocket of air in the thoracic cavity. Following this incidental finding, he had a CT chest which showed a congenital Morgagni hernia.

Discussion: Repair of CDH is considered a semi elective repair whereby it is performed after the neonate is stabilised. In our case, the patient had a large, non-strangulated, 12 cm anterior defect. The herniated contents were reduced back into the abdominal cavity and a prolene mesh was sutured to the posterior leaflets of the diaphragm and anteriorly to the rectus abdominis (the anterior leaflets were deficient). He had an uneventful post-operative course. He is being followed up as an outpatient, has decreased symptoms of reflux and is gaining weight. Is composite mesh a feasible alternative?

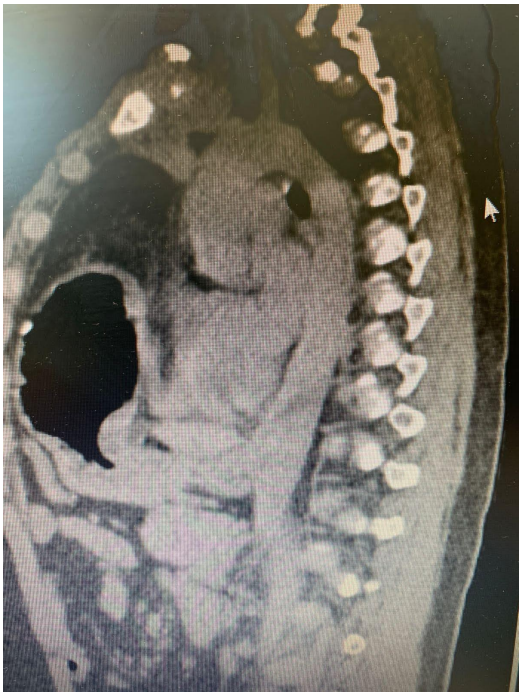


Figure 1: CT chest showing herniated abdominal viscera (pre-op)

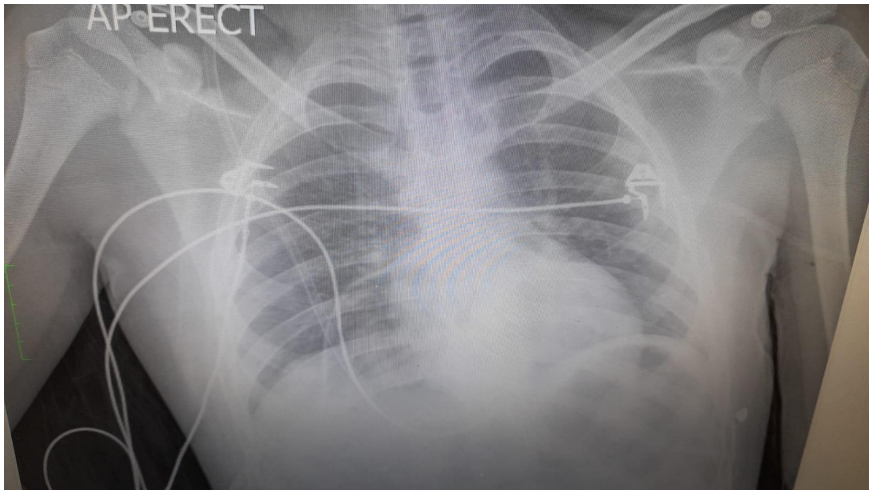


Figure 2: Chest X-ray (post-op)

13)

TITLE: Chronic elbow dislocation treated with articulated plate internal joint stabilizer

PRESENTER: Anil Kumar K

AUTHORS: Anil Kumar K, Stefan Narine, Priya Maraj, Nikhil Patel
Department of Orthopaedic Surgery,
EWMSC, Mt Hope

CONTACT: bonesandjointssurgery@gmail.com

SPECIALTY: Orthopaedics

ABSTRACT:

Introduction: The purpose of this case presentation is that we have developed a novel articulated plate internal joint stabilizer which acts as a stable internal articulated joint stabilizer and congruent reduction of the ulnohumeral and radiocapitellar joints in patients with chronic elbow instability as a result of trauma.

Case Description: This is a 57 seven-year-old male, known psychiatric patient sustained injuries to both elbows secondary to a fall. In emergency department, was diagnosed as bilateral elbow dislocations and had closed manipulations of both elbows and placed in a above elbow splint and referred to clinic for follow-up. However, due to his lack of social and family support, he did not attend clinic for next 8 weeks. After 8 weeks, clinical and x-ray examinations revealed re-dislocated stiff elbows with significant hypertrophic ossification of soft tissues and repeat closed manipulation failed. Lab investigations revealed severe anemia. While he was being treated for severe anemia and prepared for surgical open reduction, he was found to be Covid-19 positive. Only one elbow was operated on, which involved medial and lateral approach, elbow joint reduction, stabilization with articulated plate internal fixator, anterior transposition of the ulnar nerve and repair of the soft tissues.

Discussion: Internal joint stabilizer devise is commercially available however it is bulky and expensive. Our, on the table design of articulated plate internal joint stabilizer is effective and designed with readily available plate and screws.

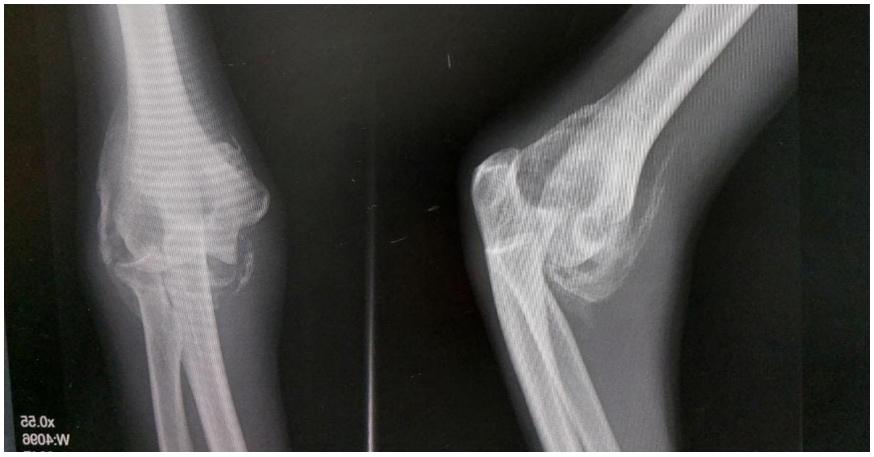


Image 1. Preoperative X-rays showing chronic posterolateral elbow dislocation with hypertrophic ossification

14)

TITLE: Not Your Typical Shunt Complication

PRESENTER: Dr. A Ramdass

AUTHORS: Dr. C Calderon, Dr. A Ramdass, Mr. D Ramnarine
Eric Williams Medical Sciences Complex, Mt. Hope

CONTACT: arianeramdass@live.com

SPECIALTY: Neurosurgery

ABSTRACT:

IntroductioN: One of the treatment options of hydrocephalus involve the placement of a ventriculoperitoneal (VP) shunt. Shunt complications are very common, especially in the first year of life. Migration of an entire shunt system to the subgaleal region is indeed rare.

Case Description: An 8-month-old infant, known hydrocephalus and seizure disorder presented with left cranial swelling 6 weeks post VP shunt insertion. The skin was shiny and tense (Figure 1). Her convoluted past medical history detailed shunt placement as a neonate with a subsequent persistent CSF leak after the procedure. Shunt revision followed 3 weeks after this first procedure. At 6 months of age, she presented once more with evidence of shunt malfunction secondary to infection. Shunt infection protocol was initiated followed by placement of a new VP shunt.

At this new presentation, an investigative shunt series showed both catheters coiled up at cranial site (Figure 2). CT brain confirmed shunt migration. A new VP shunt was inserted at the left parieto-occipital region with pericranium being used to anchor the valve. The shunt was also secured at the site of the burr hole with a 90◦connector.

Discussion: Is shunt migration an avoidable complication if intricate surgical techniques are applied? Some considered include performing smaller burr holes and durotomies, increasing the interval distance by utilizing Kocher's point and secure anchoring of catheters.

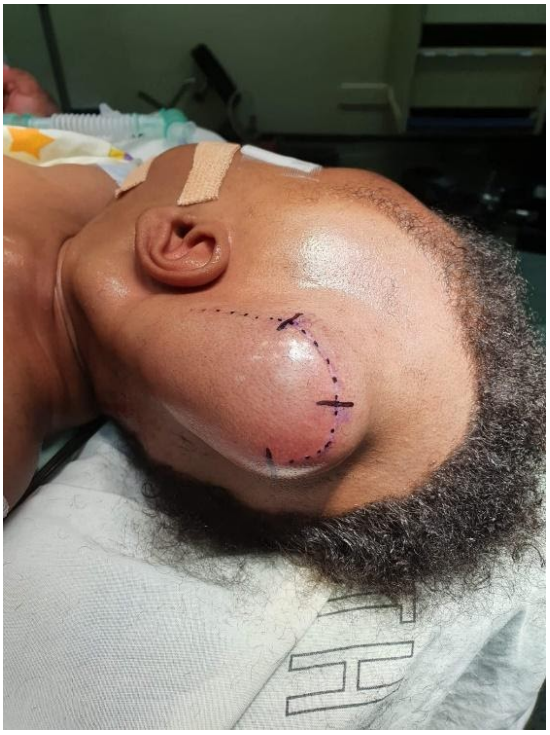


Figure 1: Image of left cranial swelling and shiny appearing skin

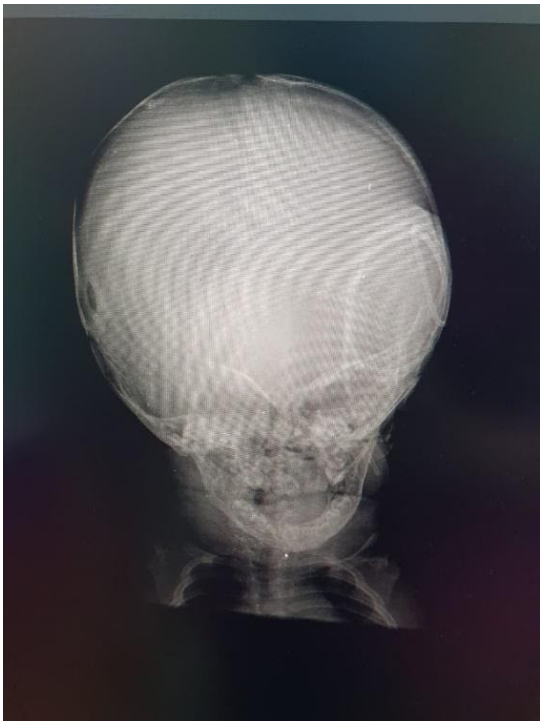


Figure 2: Shunt series (AP view): coiled catheters at cranial site

15)

TITLE: "To reverse or not to reverse?"

PRESENTER: Natalia Thompson

AUTHORS: Dr. Natalia Thompson, Dr. Vaishali Maharaj, Professor Dilip Dan
Department of General Surgery, South West Regional Health

CONTACT: natalia.thompson@gmail.com

SPECIALTY: General Surgery, Bariatric Surgery, Laparoscopic Surgery

ABSTRACT:

Introduction: RYGB is considered the gold standard for treatment of morbid obesity. Reversal is unusual and is indicated for rare but serious long-term complications.

Case Presentation: A 57-year old male had laparoscopic RYGB and cholecystectomy due to morbid obesity, complicated by severe GERD that was refractory to PPI treatment. The post-operative course was uncomplicated and initially, the desired results were attained. The patient re-presented with further unintentional weight loss, PR bleeding and spurious diarrhoea. He was diagnosed with rectal adenocarcinoma upon investigation (stage III), and subsequently underwent neoadjuvant chemoradiation and Low Anterior Resection. Post LAR, the patient experienced symptoms in keeping with LAR syndrome. These were improved with a Sacral Nerve Stimulation implant. Subsequent surveillance showed no further disease progression. He later presented to the hospital with vomiting and inability to tolerate foods. OGD showed ulceration and stricturing at the gastro-jejunal anastomotic site. After failed attempts of endoscopic dilatation, he had reversal of the RYGB which returned him to normal function and nutritional status.

Discussion: In patients who undergo RYGB, routine follow up is indicated, due to the possibility of long term complications such as gastrointestinal haemorrhage, small bowel obstruction and gastrojejunal anastomotic site strictures. These complications may warrant prompt reversal despite the long term risks of weight gain and metabolic diseases such as diabetes. Therefore, the decision to reverse requires careful deliberation and involvement by relevant specialties and ideally performed by a trained bariatric and laparoscopic surgeon.

16)

TITLE: Massive Rectal Hemorrhage from Stercoral Ulcer: A Rare Cause of a Common Presentation

PRESENTER: Samara Hassranah

AUTHORS: Samara Hassranah, Sandeep Maharajh, Vijay Naraynsingh, Sanjeev Solomon
Department of Surgery, Medical Associates Hospital, Trinidad and Tobago

CONTACT: samara.hassranah@live.com

SPECIALTY: General Surgery, Gastroenterology

ABSTRACT:

Introduction: Massive lower gastrointestinal (GI) bleeding from stercoral ulcers is exceedingly rare. We report a case of a middle aged man who presented with progressively deteriorating neurologic function with constipation and subsequent massive GI bleeding per rectum.

Case Description: A 50 year old man had progressively worsening rectal bleed and subsequently, hemorrhagic shock. He was resuscitated and planned to have the appropriate operation, a total colectomy. An emergency colonoscopy was done and a bleeding rectal ulcer was identified. Hemostasis was achieved with epinephrine injections and hemostatic clips and he was surgically discharged once stable. Eight days later, his bleeding recurred. After resuscitation, under general anaesthesia, transanal oversewing of the ulcer achieved effective hemostasis.

Discussion: Should routine colonoscopy be part of the investigative algorithm for massive lower gastrointestinal bleed? Stercoral ulcers are rare, but in patients with longstanding constipation who present with massive rectal bleed, a colonoscopy to rule out these lesions is invaluable in ensuring that the traditionally appropriate management of subtotal colectomy for massive rectal bleed is not performed inappropriately.

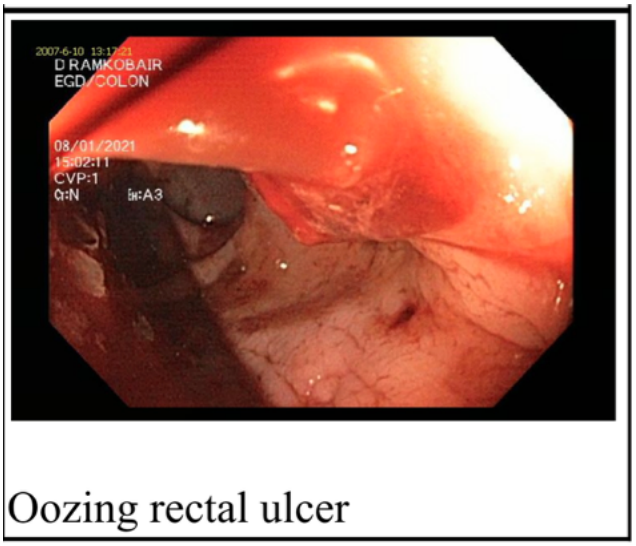


Fig. 1 The oozing rectal ulcer

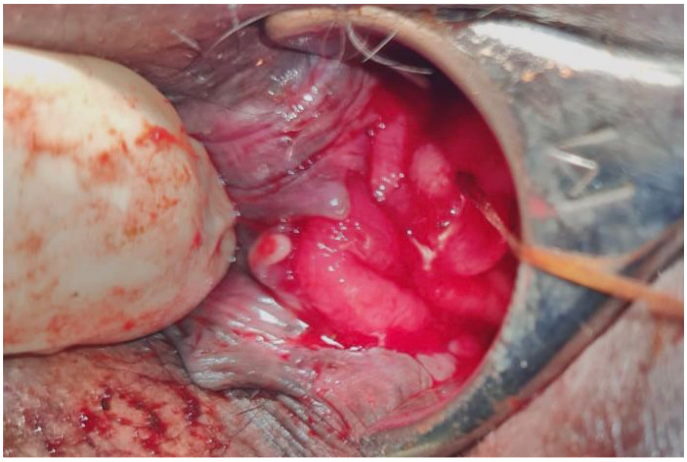


Fig. 2 The transanal oversewing of the rectal ulcer

17)

TITLE: Median Arcuate Ligament Release

PRESENTER: Shirvanie Persaud

AUTHORS: Persaud SDN, Harnanan D, Pran L, Cawich S
Eric Williams Medical Sciences Complex, Trinidad and Tobago

CONTACT: Shirvanie@hotmail.com

SPECIALTY: Vascular Surgery, General Surgery, Laparoscopy

ABSTRACT:

Median Arcuate Ligament Syndrome (MALS) is a rare diagnosis that can cause coeliac artery compression. This case reports the presentation and management of MALS and associated superior mesenteric artery (SMA) thrombosis.

Case Description: A 44-year-old hypertensive female presented with recurrent abdominal pain, nausea and bilious vomiting over four months. Mesenteric angina prompted mesenteric angiography with computed tomography (CT) revealing distal SMA thrombus and associated fat standing around normal enhancing proximal jejunum. Symptoms persisted despite oral anticoagulation. CT showed superior angulation of the coeliac axis (Fig. 1). Doppler USS confirmed a maximum expiratory peak systolic velocity of 374cm/sec within the coeliac axis, suggesting the diagnosis of MALS. Her definitive management was laparoscopic median arcuate ligament (MAL) release, jejunal segmental resection and primary anastomosis, guided by intraoperative vascular assessment, using indocyanine green (Fig. 2).

Discussion: SMA thrombosis caused critical ischemia in the proximal jejunum, when flow was decreased in the coeliac artery. This caused chronic ischemic bowel changes and mesenteric angina. The treatment of MALS restored blood flow by complete division of the MAL, relieving the extrinsic compression of the coeliac artery. Intra-operative vascular assessment guided extent of resection of the jejunum.

Conclusion
This case of laparoscopic MAL release and intra-operative vascular assessment demonstrated the rare case of MALS.

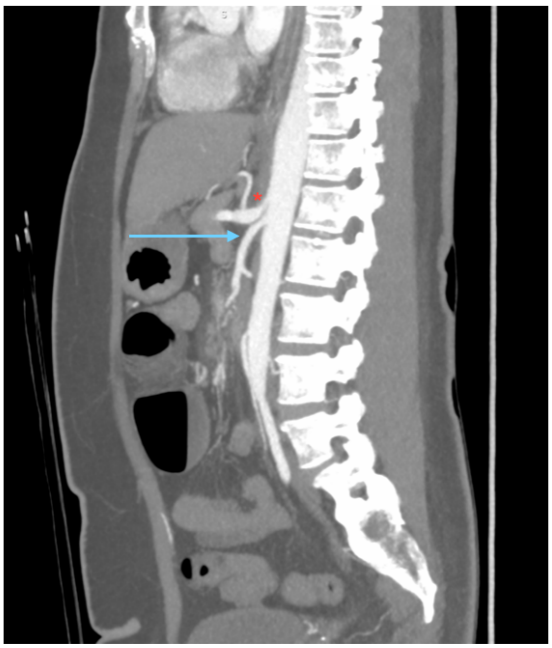


Fig. 1 Sagittal view of CT-mesenteric angiogram showing superior angulation of the coeliac axis (*) and close proximity of SMA(arrow)

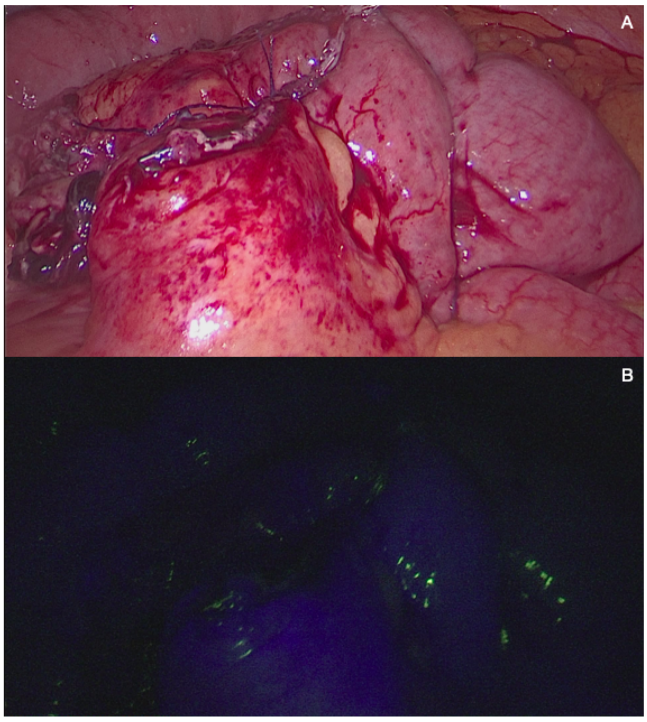


Fig. 2 showing laparoscopic view of A- Stapled edges of jejunum before anastomosis and B- Indocyanine Green demonstrating perfusion of stapled edges.

18)

TITLE: Laparoscopic Approach to Giant Splenic artery Aneurysm

PRESENTER: Y Raghunanan

AUTHORS: Y Raghunanan, D Harnanan/ L Pran/ D. Dan
Department of Surgery, EWMSC

CONTACT: Bradraghu@hotmail.com

SPECIALTY: Vascular Surgery.

ABSTRACT:

Introduction: Mesenteric artery aneurysms are very rare intra abdominal aneurysms. Although risk of rupture and life threatening hemorrhage is significant, the management of these cases are not well defined.
With the increase in use of CT scanning, the incidence of asymptomatic MAA are increasing. In this case we describe a case of an asymptomatic splenic artery aneurysm and the decision for laparoscopic repair.

Case: A 79 year old male, known smoker and hypertensive, found to have an incidental SAA, 5.2cm x 4.9cm in the distal third of the splenic artery was seen.
On interviewing, no history of alcohol abuse, gallstones or recurrent pancreatitis was described.
The patient subsequently underwent a laparoscopic aneurysmectomy with splenectomy. The postoperative course was uneventful and histology reports post op revealed a 5cm x 5cm x 5cm SAA with myxoid degeneration of the media and an unremarkable spleen.

Discussion: Splenic artery aneurysms are the most common MAAs and the 3rd most common intra-abdominal aneurysms to occur. Although rare in overall incidence, the risk of rupture of these aneurysms is considerable and the need for monitoring and repair is warranted.
With the advancements and ease of access to CT imaging, both diagnosis and monitoring has been established. The decision for interventions and the choice of open versus endovascular repair is yet to be finalised. We discuss a case of a giant splenic artery aneurysm and the factors that led to the decision of a laparoscopic resection and splenectomy.

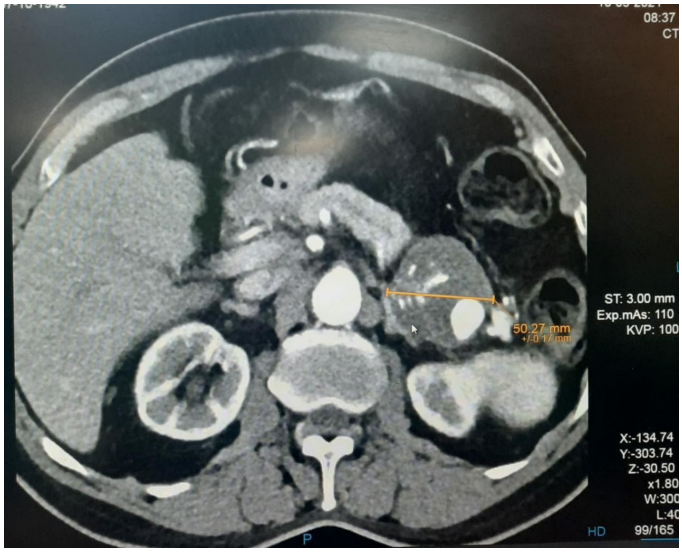


Figure 1. Axial view of CT mesenteric angiogram showing a 50.27mm splenic artery aneurysm

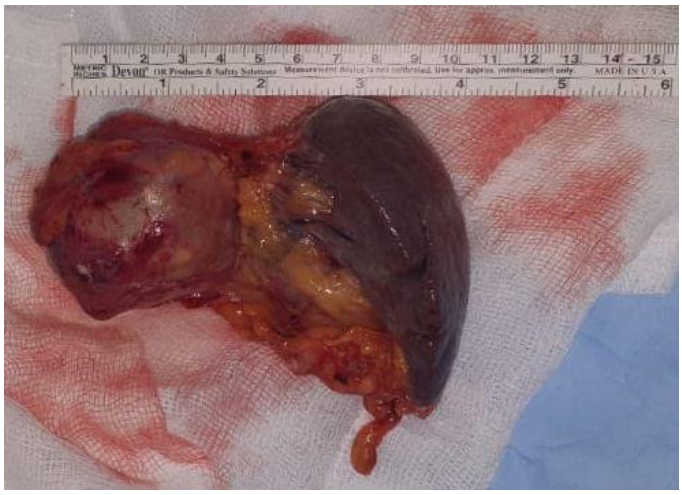


Figure 2. Specimen of laparoscopic resection of splenic artery aneurysm and splenectomy.

19)

TITLE: Pushing the Boundaries of Colorectal Liver Metastasectomy.

PRESENTING AUTHOR: Chaunique Rique

AUTHORS: Rique C, Persaud SDN, Raghunanan B, Maharaj R
Eric Williams Medical Sciences Complex, Trinidad and Tobago

CONTACT: Chaunique.r.rique@gmail.com

SPECIALTY: General Surgery, Hepatobiliary, Oncology

ABSTRACT:

Introduction: This report highlights the management of colorectal liver metastases (CRLM) after malignant transformation of ulcerative colitis (UC).

Case: A 58-year-old male with UC for over 20 years presented with constipation and per rectal bleeding for six-months. Colonoscopy revealed a constricting rectal mass, confirmed adenocarcinoma on histology. Staging computed tomography (CT) showed bilobar CRLM prompting a referral for palliative chemotherapy. Chemotherapy produced partial tumour response but exacerbated UC symptoms. Positron Emission Tomography-CT (PET-CT) showed uptake in hepatic segment 1 and non-avid segment 3 lesion (fig. 1). He had panproctocolectomy, end ileostomy, along with left lateral sectionectomy and microscopically-involved caudate lobe resection (fig. 2). After an unremarkable recovery, he was referred for stereotactic radiotherapy to the liver; pelvic radiation and continued palliative chemotherapy.

Discussion: Resection of all involved hepatic segments and primary tumour is required for cure. The extent of hepatic resection must be balanced with an adequate future liver remnant; facilitated by a variety of staged operations. This patient was considered for panproctocolectomy to treat UC symptoms. Multidisciplinary team (MDT) additionally recommended resection of CRLM demonstrated on PET-CT.

Conclusion: This patient with CRLM, whose chemotherapy worsened his symptoms of UC, had panproctocolectomy and end ileostomy along with resection of segment 1 and 3 CRLM. Radiological imaging shows no evidence of disease (NED).

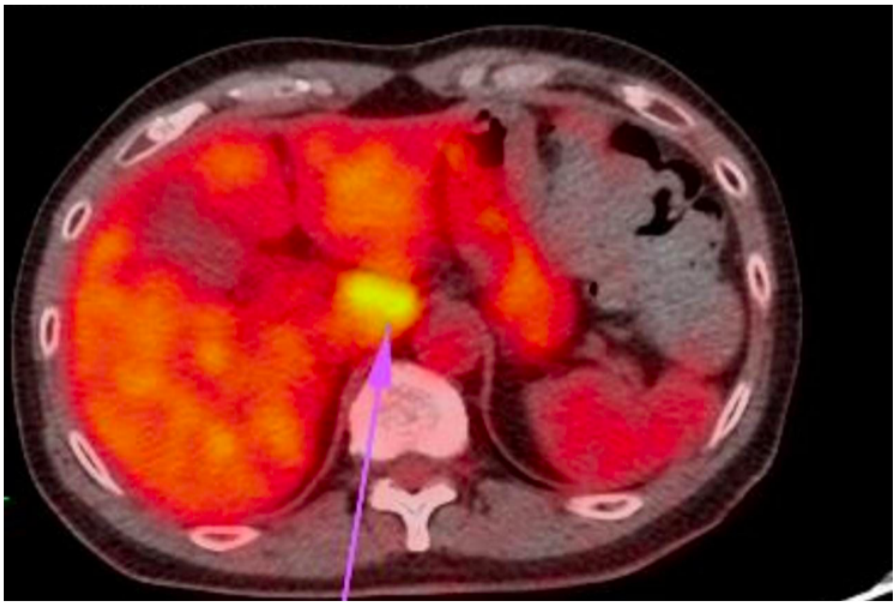


Fig. 1 showing uptake in segment 1 liver lesion (arrow) (SUV max=5.0)

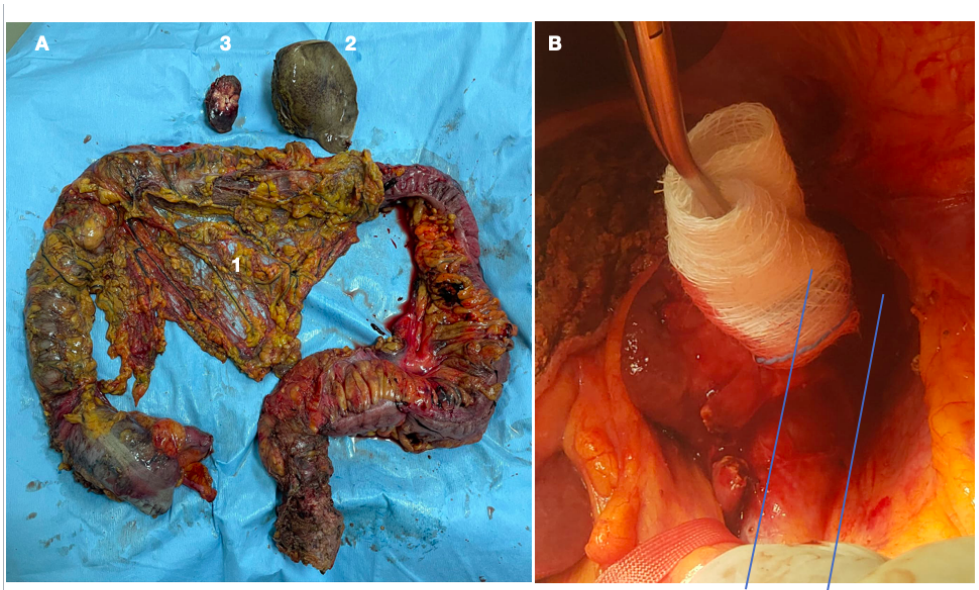


Fig. 2 showing A-1) panproctocolectomy, 2)left lateral sectionectomy 3) caudate resection specimen and B-intra-operative relation of the caudate lobe CRLM to the vena cava (blue lines)

20)

TITLE: Small Bowel Obstruction Secondary To An Internal Hernia Through The Pouch Of Douglas: A case Report and Review of The Literature

PRESENTING AUTHOR: Elizabeth Guelmo- Daisley

AUTHORS: Elizabeth Guelmo- Daisley, Ariadne Saunders, Richard Spence, Shamir Cawich
Department of Surgery, Port of Spain, General Hospital

CONTACT: egdmed54@gmail.com

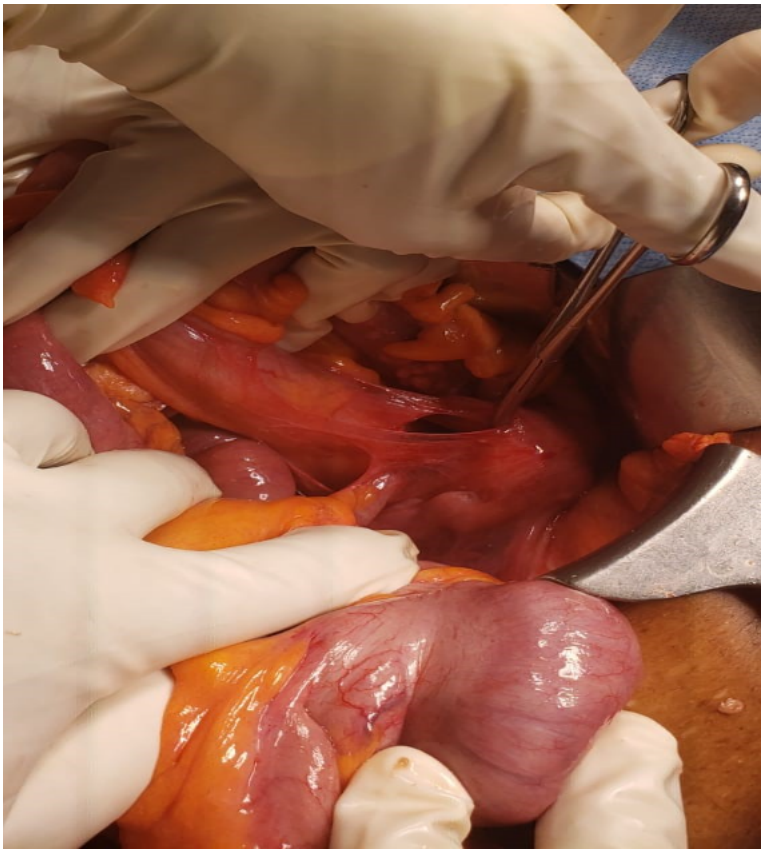
SPECIALTY: General Surgery

ABSTRACT:

Background: Internal hernias are an uncommon cause of small bowel obstruction. These are caused by the protrusion of viscera through defects in the mesentery or peritoneum. Pouch of Douglas hernias are an exceedingly rare type of internal hernia. As such, there are no standard guidelines for management.

Case presentation: An elderly female presented with signs and symptoms of small bowel obstruction in a virgin abdomen. She was found to have a recto uterine cul- de- sac or pouch of Douglas hernia on CT scan. She went on to have open reduction and herniotomy after which she made a full recovery.

Discussion: Pouch of Douglas hernias are a rare type of internal hernia. A review of the literature revealed less than 10 cases have been described. It may be due to a congenital defect in the peritoneum or due to an acquired defect usually secondary to previous pelvic procedures. It may be identified via CT and the definitive management is surgical due to the high risk of strangulation. Herniotomy or widening of the hernia defect was done for this case and appears to be a valid method of definitive management of hernias within the Pouch of Douglas.



21)

TITLE: Bronchovenous Fistula on Cardiopulmonary Bypass During an Emergency Open Thoracic Aneurysm Repair - A Case Report.

PRESENTER: Ilecia Baboolal

AUTHORS: Dr. Ilecia Baboolal Mr. D Harnanan/ Dr. L Pran/ Dr. W Mohammed
Eric Williams Medical Sciences Complex, Trinidad and Tobago

CONTACT: dr.i.baboolal@gmail.com

SPECIALTY: Vascular surgery, Cardiothoracic surgery

ABSTRACT:

Introduction: Broncho-venous fistula (BVF) is a very rare complication and is usually described in relation to lung trauma and in neonates. There are very few documented cases of BVF in adults during cardiopulmonary bypass. We report a case of systemic arterial air embolism (SAAE) complicating open repair of a ruptured descending thoracic aneurysm and aorto-bronchial fistula, while on cardiopulmonary bypass.

Case Description: A 55-year-old patient was placed on beating heart cardiac bypass for the open repair of a ruptured type C descending thoracic aneurysm complicated by an aorto-bronchial fistula. After an uncomplicated graft replacement and primary repair of bronchial fistula, weaning off bypass was complicated by a significant amount of air within the left heart associated with ST elevations and poor cardiac ejection. Despite multiple attempts at de-airing, positive pressure ventilation consistently resulted in re-accumulation of air with in the cardiac chambers and its sequelae. The patient was unable to be weaned off cardiac bypass and the consequence of SAAE worsened her condition to the point where she could not be weaned off bypass and subsequently expired.

Discussion: To our knowledge there have been 3 other documented cases of BVF occurring in adults during cardiopulmonary bypass with poor outcomes. There has been very little documentation in regards to recognising and treating this issue. We seek to highlight ways to diagnose this problem and review available data on treatment options that may be available.

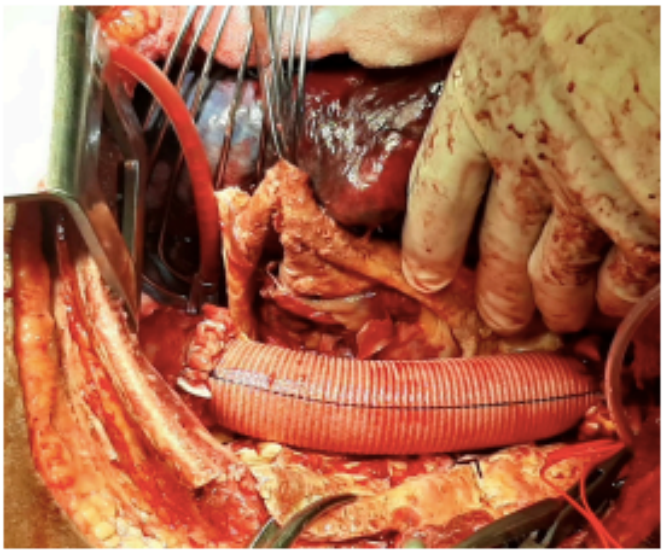


Figure 1. Knitted vascular graft within aneurysm sac distended with blood

Figure 2. Air bubbles visualised on TOE demonstrating air in the left atrium and ventricle