THE SOCIETY OF SURGEONS OF TRINIDAD AND TOBAGO

In Conjunction with the ACS Chapter Trinidad and Tobago

NATIONAL GRAND ROUNDS:

SUNDAY NOVEMBER 11TH 2018

Abstract Submissions

RECURRENT RECTOVAGINAL FISTULA "How many times it takes to fix the Vagina?"

Authors: Mr. Hassranah D, Dr. Olivier L ,Dr.Belleza N, Joseph K Department :General Surgery
Institution: Sangre Grande Hospital
Presenter: Joseph K
Address: Sangre Grande Hospital ,Ojoe Rd, Sangre Grande Mobile : 783-0791
Email: Karenasj@hotmail.com

Introduction:

Recto-Vaginal Fistula (RVF) is defined as an abnormal communication between rectum and vagina. Although there are several surgical techniques to correct such imperfection, management still seems a test for the surgeons . It accounts for 5% of all anorectal fistula and presents as an annoyance to the patient with passage of flatus or stool from the vagina ,faecal incontinence, vaginitis etc.

Case Description:

This case report identifies with a young 22 year old female during the delivery of her first child who suffered from a grade 1V vaginal laceration during delivery and was repaired four (4) times until the use of a Modification of the Martius Flap.

Discussion:

This case will review the failed attempts and methods used until success was reported on the fifth surgical procedure, so the question remains, what is the best surgical approach to repair a RVF once?

BIOPSY OF OCCLUSIVE OESOPHAGEAL LESIONS UTILIZING A RETROGRADE ENDOSCOPIC APPROACH.

Rambhajan A., Guelmo E.

ABSTRACT:

Introduction And Objective:
Oesophageal perforation is the most feared complication of the blind ante grade endoscopic approach to occlusive oesophageal lesions. Oftentimes the procedure is abandoned in severely constrictive disease. The retrograde endoscopic approach to stenotic oesophageal lesions, when used alone or in combination with the ante grade approach, reduces the risk of this complication. The technique is a simple and has many applications. This case study describes the use of this procedure to biopsy a stenotic lesion deemed inaccessible via the ante grade approach in a patient at the Port- Of- Spain General Hospital.

Case Presentation:
This patient had multiple failed attempts at endoscopic intubation of his oesophagus. He was referred to General Surgery for biopsy of his oesophageal lesion and placement of a feeding gastrostomy. After gaining access to the stomach via a mini laparotomy and creation of an open gastrostomy, a slim endoscope was placed in the stomach and advanced through the distal oesophagus towards the lesion. A biopsy was taken and the scope was then retracted. The feeding gastrostomy was then completed.

Discussion:
Despite having severe oesophageal stenosis, the patient was successfully biopsied using this procedure. Hence, oesophageal lesions may be safely manipulated using the retrograde endoscopic approach. This technique provides an alternative solution to the management of oesophageal strictures that is less invasive and complicated than existing surgical methods.

ADENOCARCINOMA OF THE JEJUNUM THAT WAS TOO CLOSE FOR COMFORT.

Authors: Dr. R. Maharaj, Dr. R. Spence, Dr. K. Ragbir, Dr.A.Sattaur
General Surgery Department: Eric Williams Medical Sciences Complex, Trinidad.
Presenting Author: Dr K. Ragbir
Email: Kevianne@gmail.com

Introduction

Adenocarcinoma of the jejunum are amongst the rarest types of gastrointestinal cancers, due to their infrequent occurrence jejunal cancers are usually challenging to diagnose. These tumors often present at a late stage and as a result have a poor prognosis. We report a case of a Jejunal adenocarcinoma where early diagnosis and treatment lead to a good outcome.

Case presentation

A 59-year-old female presented a with two-week history of vomiting and weight loss with no abdominal examination findings. A computed tomography scan of the abdomen was done on her 1st presentation that reflected an irregular nodular circumferential mass in the proximal jejunum. The patient was then referred to an endoscopist who five days later performed an urgent push enteroscopy where he found a large circumferential non-obstructing tumor in the proximal jejunum approximately 7cm from the dudodenaljejunal flexure. The patient was referred to our surgical service where she underwent curative resection and retro colic duodenjejunostomy and then referred for chemotherapy.

Discussion

This case is reported to arouse a clinical suspicion of small bowel adenocarcinoma in patients with gastrointestinal symptoms of unknown cause in Trinidad and Tobago. Surgical resection with clear margins and regional lymph node resection remains the treatment of choice in localized small bowel adenocarcinoma however to date there are no standard guidelines for resection. Our patient had a tumor that was approximately 7cm from the jejunal flexure which presented us with a surgical dilemma as a result retro colic duodenjejunostomy was performed.

SHORT BOWEL SYNDROME: CAN WE AVOID IT?

A Haralsingh[1], R Maharaj[2]
[1] – House Officer, Department of Surgery, Eric Williams Medical Sciences Complex.
[2] – Senior Lecturer, Department of Clinical Surgical Sciences, The University of the West Indies, St. Augustine.
Telephone and E-mail: A. Haralsingh: aaronharalsingh777@gmail.com (685-6207)
R. Maharaj drravimaharajuwi@gmail.com (498-7091)
Presenting Author: A. Haralsingh
Specialty: General Surgery
Word Count: 248

Introduction:
Severe depletion of the absorptive capacity of the small bowel either due to functional or anatomical loss leads to short bowel syndrome. Performing an anastomosis in a critically ill patient after extensive adhesiolysis and prolonged intraoperative course is usually ill-advised.

Case Description:
A 55-year-old female was referred from the Gynaecology service with a 3-week history of bilious vaginal discharge following a total abdominal hysterectomy and bilateral salpingo-oophorectomy. Radiological investigations confirmed an enterovaginal fistula. The Urology service managed pre-operative stenting of the left ureter but were unable to stent the right. Intra-operatively, dense adhesions were identified throughout the peritoneal cavity with the ileum, left colon and upper rectum firmly adherent to the pelvis deep to the vaginal vault. Unhealthy sigmoid colon, upper rectum and distal ileum were resected with completion colectomy and an end-ileostomy was fashioned. Over the past year since her surgery, this patient has been frequently readmitted to hospital for dehydration and electrolyte imbalance suggestive of short bowel syndrome.

Discussion:
Short bowel syndrome presents many challenges with only limited options for management including total parenteral nutrition and transplant and non-transplant surgical procedures. However, could this case of short bowel syndrome have been avoided altogether?

A DIAGNOSTIC DILEMMA FOLLOWING PANCREATICODUODENECTOMY

A Haralsingh[1], J Jarvis[2], R Maharaj[3]
[1] – House Officer, Department of Surgery, Eric Williams Medical Sciences Complex.
[2] – General Surgery Resident, Department of Clinical Surgical Sciences, The University of the West Indies, St Augustine.
[3] – Senior Lecturer, Department of Clinical Surgical Sciences, The University of the West Indies, St. Augustine.
Telephone and E-mail: A. Haralsingh: aaronharalsingh777@gmail.com(685-6207)
J. Jarvis: johnkjarvis@gmail.com (753-4413)
R. Maharajdrravimaharajuwi@gmail.com (498-7091)

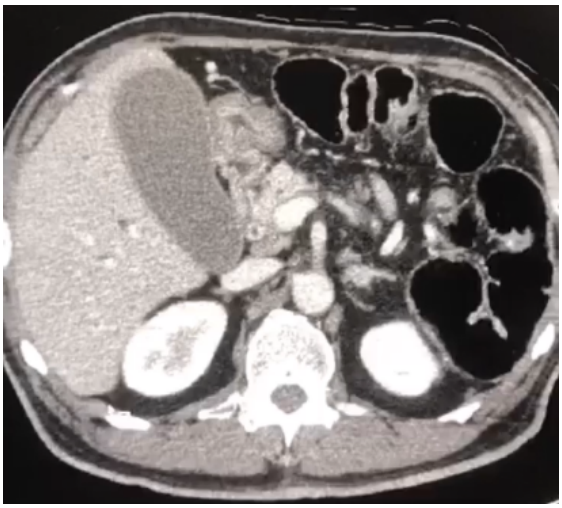
Presenting Author: A. Haralsingh
Specialty: General Surgery
Word Count: 238

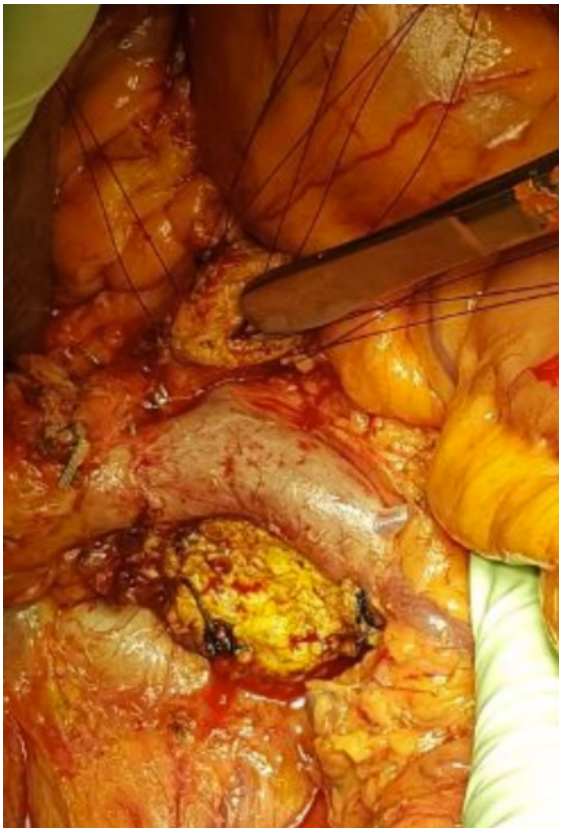
Introduction:
Cholangiocarcinoma carries a poor prognosis as most patients present with distant metastases. The intra-abdominal organs, lymph nodes and lungs are the most frequent sites of metastasis. In patients with resectable disease who have distal common bile duct involvement, a Pancreaticoduodenectomy is often required. We present the case of a patient who rapidly deteriorated in the post-operative period, likely due to undetected leptomeningeal carcinomatosis.

Case Description:
A previously well 60-year-old male presented with symptoms and signs of obstructive jaundice. Radiological investigations confirmed a mass in the distal common bile duct, likely cholangiocarcinoma with no evidence of metastasis. A Pancreaticoduodenectomy was performed with an uneventful early perioperative course. On day 9 however, on the verge of discharge, he became disoriented and developed a fever. He suffered several seizures with associated apnoeic spells and his neurological function deteriorated rapidly. An exhaustive list of investigations followed, finding only a small subhepatic collection which was drained percutaneously, but nothing else. His demise came on post-operative day twenty-one.

Discussion:
Post-operative complications of a pancreaticoduodenectomy are common and typically linked to anastomotic failure resulting in leaking of exocrine pancreatic secretions. Leptomeningeal carcinomatosis is a rare finding in cholangiocarcinoma but must be considered in the work-up of these patients when neurological symptoms arise. What is the best approach in the investigation and management of neurological symptoms and signs which arise post-pancreaticoduodenectomy and what are the differential diagnoses in this case?

Images





LAPAROSCOPIC MANAGEMENT OF A GIANT PANCREATIC

PSEUDOCYST

Authors: Dr Nahmorah Bobb, Dr Dale Hassranah, Dr Alan De Freitas, Dr Lyronne Oliver
Affiliation: Department of General Surgery
Sangre Grande Hospital
Telephone number: 748-7427
Email address: nahmorahbobb@gmail.com

Introduction:
Pseudocysts occur in 5% to 15% of patients with acute pancreatitis and up to 40% of patients with chronic pancreatitis. Asymptomatic pseudocysts up to 6cm are observed but larger and symptomatic pseudocysts require intervention. A cyst with a diameter of more than 10cm is termed a giant pseudocyst and these are much less common.

Case:
A 36 year old male with a history of necrotizing pancreatitis presented to our rural hospital complaining of abdominal pain. MRCP noted cholelithiasis and choledocholithiasis and a giant pancreatic pseudocyst 24 x 24 x 10cm. An ERCP was subsequently performed to remove the common bile duct calculi. Two weeks later a laparoscopic cystojejunostomy and cholecystectomy was performed, 6L of fluid was aspirated from the cyst prior to cystojejunostomy. His recovery was uneventful, and he was discharged four days post operatively.

Discussion:
We report on the management of the 5th largest pseudocyst documented in the literature. Giant pseudocysts are less likely to resolve with non-operative management and have a higher incidence of complications such as haemorrhage and infection early in the course of the disease. Although cystogastrostomy is a more expeditious procedure, it is preferable to perform a cyst-jejunostomy in this patient population because these large cysts often need more gravity-dependent drainage. Laparoscopic internal drainage is associated with resolution of pseudocyst in 98.3% of patients, a shorter length of hospital stays and less morbidity.

Conclusion:
Laparoscopic cystojejunostomy is feasible and a safer option in giant pseudocysts compared to cystogastrostomy.

ADULT INTUSSUSCEPTION: AN UNCOMMON YET IMPORTANT DIAGNOSIS

Rattan J[1] ,Milne D[1] , Rambhajan A[1]
[1] Port of Spain General Hospital

Presenting Author – Rattan J rattanjason@gmail.com 715-2704
General Surgery

Introduction

Intussusception of the bowel is defined as the telescoping of a proximal segment of the bowel within the lumen of the adjacent segment. This condition, although frequent in the paediatric population, occurs in 0.003 – 0.02% of the adult population.

Case Description

We present a case of a 44 year old female who was admitted with a history of vague chronic abdominal pain. The patient subsequently developed subacute intestinal obstruction. A Computed Tomography of her abdomen was suggestive of a colo-colonic intussusception.

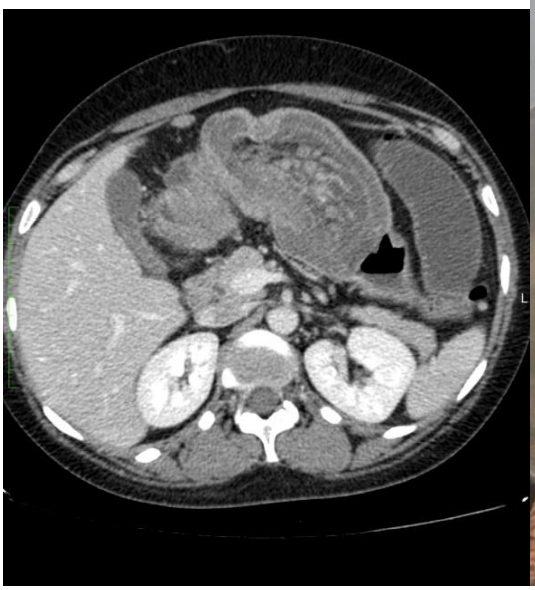
The patient went on to have an exploratory laparotomy which revealed a right colonic intussusception. Pathologic examination showed the lead point to be a colonic adenocarcinoma.

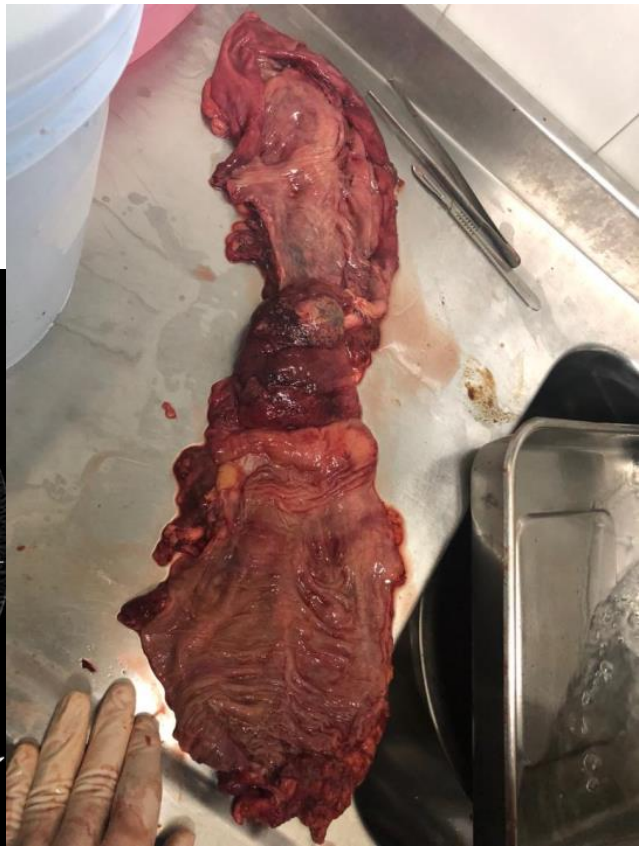
Discussion

Intussusception in the adult occurs more often in the small bowel with only 38% occurring in the colon. Although infrequent, a high suspicion for this condition must be had as 66% of the lead points in colonic intussusception is a malignant neoplasm with adenocarcinoma being the most common.

Conclusion

Colonic intussusception in the adult is an uncommon cause of intestinal obstruction but it is important to keep in mind because of its variable presentation and increased likelihood of underlying malignancy.





EOSINOPHILIC COLITIS: A RARE PRESENTATION OF COLON CANCER

AUTHORS**:** A. Muddeen,D.Milne, J. Rattan,A. Rambhajan

PRESENTOR:Alyssa Muddeen
PGY 3 DM General Surgery Resident
Port of Spain General Hospital
(868) 780-0687
alyssa.arianne@gmail.com

INTRODUCTION:

We present a case of a patient whose biopsy at colonoscopy revealed Eosinophilic Colitis (EC) which led to a delay in the diagnosis and subsequent treatment of colon cancer.

CASE HISTORY:

A 35 year old male presented with a six week history of right lower quadrant abdominal pain associated with diarrhea and weight loss. Colonoscopy showed an inflamed cecum and a CT revealed a small ascites fluid collection in the right iliac fossa. Biopsy showed Eosinophilic Colitis and he was treated conservatively with albendazole and then mesalamine. Patient failed to improve over the following month with continued weight loss and a repeat CT scan showed a new right iliac fossa mass. A right hemicolectomy was performed with histopathology from the specimen showing mucinous adenocarcinoma.

DISCUSSION:

Eosinophilic gastrointestinal disease (EGID) is a rare condition of unknown etiology and is characterized by eosinophil rich, chronic inflammation of the gastrointestinal tract with Eosinophilic Colitis (EC) being the rarest form of EGID. Similarly, colon cancer can also contain large numbers of eosinophils and these are noted in 75% of colon cancer specimens. There is only one other documented case of EC with colon cancer and it is proposed that the chronic inflammation of EC may predispose to the development of colon cancer.

QUESTION:

Was Eosinophilic Colitis a misdiagnosis? Or can it be regarded as a possible risk factor for the development of colon cancer?

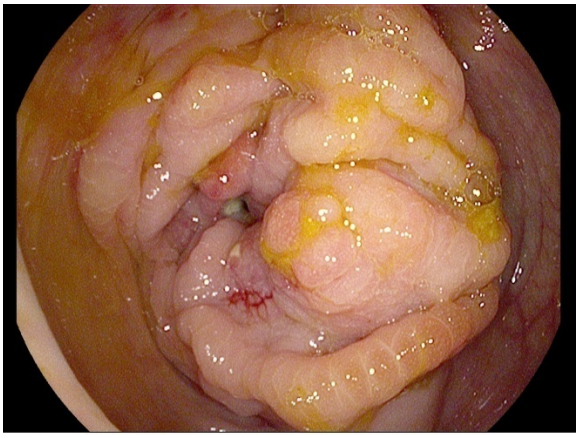


Figure 1: Edematous, inflamed cecum with pus seen at colonoscopy

NOTHING BUT N.E.T.

Authors: J Jarvis, D Sirjuesingh, I Aziz, T Lum, Y Singh
Affiliation: San Fernando General Hospital
Telephone number: 753-4413
Email address: johnkjarvis@gmail.com
Word Count: 244

Introduction:
The association between inflammatory bowel (IBD) disease and intestinal tumors have well been established. The risk of colon cancer is estimated to be 2.6 times higher in IBD patients. The incidence of neuroendocrine tumors (NET) accounts for 2 per 100, 000. Simultaneously occurring with IBD is exceedingly rare.

Case Descriptions:
A 51 year old Afro-Trinidadian male presented with acute bowel obstruction and perforation from a large inflammatory bowel mass. He was diagnosed with Crohn's disease (CD) ten years prior and admitted to non-compliance with his medication and follow up. The surgical history included an appendectomy at 30 years. The patient underwent an emergency ileocecal resection, involving a substantial length of ileum. The pathology identified in the specimen was a Grade 3 neuroendocrine tumour, occurring away from the site of active CD.

Discussion:
In 1986, there were 9 reported cases of NET coexisting with CD. In 1997, this increased to 16. In 2011 there were 53 cases reported internationally thus far. Few studies since then have explored the relationship between these two entities. West et al. published an odds ratio of 15 when comparing to the general population, however none occurring at sites of active disease. Sigel et al. investigated more specifically the region of occurrence which contrasted the findings of West. They claimed that NET occurred at adjacent sites of active IBD. We explore the literature to determine whether this rare incidental finding is in fact causation or correlation.

IATROGENIC CAUSE OF CAVERNOUS SINUS THROMBOSIS

Dr.Juman, Dr. Fundora, Dr. Koonoolal

PRESENTING AUTHOR: Dr. Koonoolal (Koonoolal@gmail.com)
SPECIALITY: ENT

Abstract:

Background:
Septic cavernous sinus thrombosis (CST) is a rare condition that can result in high mortality and morbidity rates if not treated immediately. CST may be aseptic or septic. Less common primary sites of infection include the tonsils, soft palate, middle ear, and orbit. This case report is one of an iatrogenic cause of septic cavernous sinus thrombosis.

Case Report:
NM, 43year male, known hypertensive patient who presented to EWMSC with history of epistaxis which required anterior and posterior nasal packing. Patient complained of headaches and facial pain. Nasal packs were removed but patient continued complaining of pain and periorbital swelling. CT scan was done showing air pocket density in region of nasal bone. Patient progressively deteriorated to having orbital swelling chemosis and CN palsy.

Discussion:
Patients with cavernous sinus thrombosis present with headache, fever, vomiting, facial redness and pain, and eyelid edema. The most frequent signs are fever, proptosis, chemosis (due to obstruction of the ophthalmic veins) and cranial nerve palsies (III, IV, V(1), VI), leading to ptosis, ophthalmoplegia and supraorbital paraesthesia. Within 24–48 h, spread of the clot through the circular sinus to the contralateral cavernous sinus may result in bilateral signs and symptoms. This case report of cavernous sinus thrombosis shows the necessity for a high level of vigilance in management.

MALIGNANT OTITIS EXTERNA PRESENTING AS A CVA

Dr. Juman, Dr. Fundora, Dr. Koonoolal
PRESENTING AUTHOR: Dr. Koonoolal (koonoolal@gmail.com)
SPECIALITY: ENT

ABSTRACT:

Background:

Malignant Otitis Externa is a rare but aggressive life threatening condition which usually affects the immunocompromised individuals especially uncontrolled diabetics and what starts as a simple otitis externa rapidly develops to osteomyelitis of the temporal bone and can lead to nerve palsy and intracranial abscess development. Malignant Otitis Externa is regarded as a rare disease, here we present one of the five cases seen at EWMSC over the last three months for which patient presented as a stroke.

Case Report:
This is a case of GM 55-year-old male known DM, CKD with previous leg amputation for a diabetic foot who presented to EWMSC with facial asymmetry for 2 days and thought he was having a stroke. Patient gives a background history of 6 weeks of otalgia and otorrhea which (progressively worsened) Multiple visits to LHC and GP with no alleviation of symptoms. Patient eventually presented to AED when he began developing facial asymmetry. Clinical findings at presentation revealed right facial nerve palsy (House Brackmann 4/6) Right-sided facial swelling with otorrhea and stenotic External Auditory Canal. Patient known CKD requiring renal adjusted dose of Zosyn. Lack of resolution and elevating ESR, a CT scan of head was done which showed sequestrum and required debridement. On ward patient developed chest pains and discovered to be having MI.

Discussion:
Management of malignant otitis externa with facial nerve palsy and persistent otorrhea was complicated by renal impairment and MI.

ANSA-SPINAL ACCESSORY NEURORRHAPHY: PREVENTION OF SHOULDER SYNDROME

AUTHORS: L. Noel, S. Medford, T. Seepaul, S. Juman

INTRODUCTION:
The treatment of metastatic neck cancer depends on complete oncological tumour resection while preserving the patient's quality of life. A major post neck dissection complication described in the literature is shoulder dysfunction from injury to the spinal accessory nerve (SAN). This nerve injury leads to atrophy of the trapezius muscle with the onset of shoulder dysfunctions; pain, shoulder drooping, weakness and limited range of motion. We present the first and successful case of an Ansa-spinal accessory neurorrhaphy post neck dissection.

CASE HISTORY:
A 60-year-old female presented to the ENT department with a left parieto-temporal scalp lesion and left cervical mass. After confirmation of metastatic squamous cell carcinoma of the scalp, the patient had removal of the primary lesion and left modified radical neck dissection. The left sternocleidomastoid muscle and spinal accessory nerve were involved in the tumour mass and thus removed. An ansa-spinal accessory end to end neurorrhaphy was then performed to prevent shoulder dysfunction (figure1). Five months later the patient has no shoulder pain, weakness and has full range of motion.

DISCUSSION:
Associated shoulder disabilities after neck dissection was first described In 1952 by Ewing and Martin. Its incidence ranges from 33%-66%. This shifted the paradigm from radical neck dissections to modified radical, selective or super selective neck dissections where the SAN can be preserved. However in the event that the SAN has to be sacrificed we propose Ansa-SAN neurorrhaphy.

QUESTIONS:
Is this novel technique likely to be successful in preventing shoulder syndrome and should it be implemented when possible?

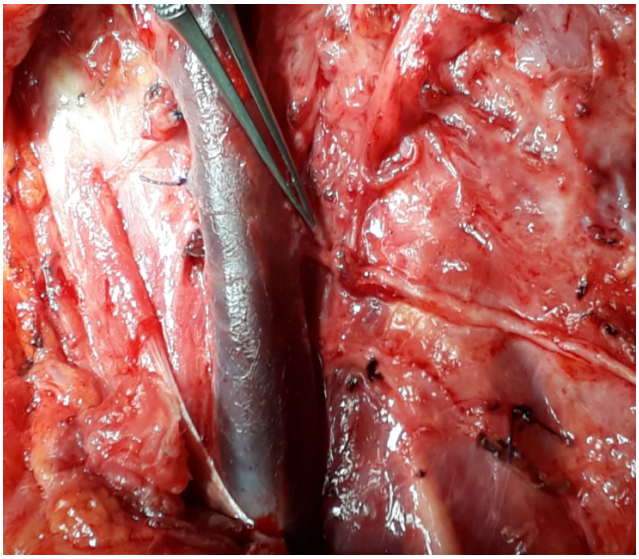


Fig. 1 shows the end to end anastomoses of the ansa to the spinal accessory nerve.

THE CASE OF THE DISAPPEARING ULNA

Authors: M. Augustus, A.Beharry, C. Quan Soon

Authors Affiliations:M.Augustus (M.D), A.Beharry (MBBS, DM Orthopaedics), C.Quan Soon (MBBS, AFRCS, DM Orthopaedics)

E-Mail contact: meganaugustus@live.com, allan_beharry@hotmail.com, cquansoon@gmail.comTelephone contact: 788-9400, 763-0951, 757-6231

Presenting Author:M.Augustus

Specialty:Orthopaedics

Introduction

Congenital pseudarthrosis is a rare condition, which has a high correlation with neurofibromatosis type 1(NF1). This case report highlights this association. Clinical signs are not always present at birth and may become evident during development. The pathogenesis is not clearly understood; these are some of the most difficult orthopaedic cases due to difficulty to attain and maintain union.

Case

At five weeks of age this patient sustained a distal ulna fracture secondary to trivial trauma that was managed conservatively. Over the course of seven years, he had progressive bowing of the radius and radiological “disappearance” of his distal ulna.

He self-referred to a tertiary center because of worsening deformity; café-au-lait spots and neurofibromas were noted on clinical exam. These findings led to the diagnosis of NF1.

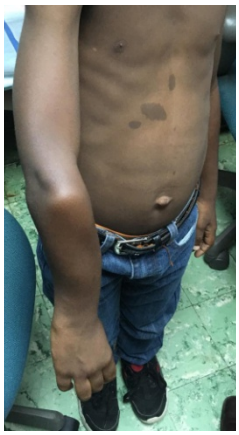


Image 1: Illustration of forearm deformity

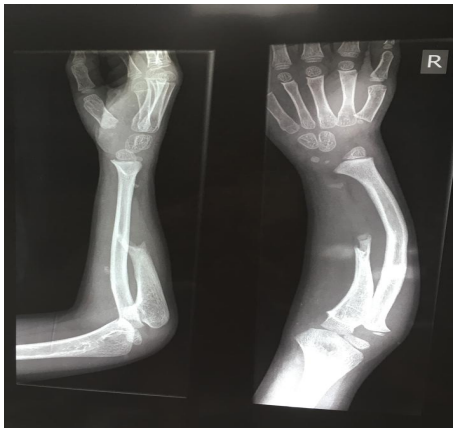


Image 2: Xray illustrating disappearance

Discussion

NF1 is an autosomal dominant disorder, with a mutation or deletion of NF 1 gene, which has multi-systemic manifestations. The earliest sign is café- au- lait spots, which were only noted at seven years of age in our patient. NF1 has a 50% incidence in congenital pseudarthrosis cases. On review of the literature, there have been fourteen cases involving the forearm bones. Pseudarthrosis cases, which are associated with NF1, are more difficult to treat and have a poorer prognosis.

KNEE ARTHRODESIS FOR A FAILED TOTAL KNEE ARTHROPLASTY: A THIRD WORLD SOLUTION

Authors: Atiba Aki Bua, Raakesh Goalan Marlon M. Mencia
Author Affiliations:
Atiba Aki Bua - Port of Spain General Hospital
Raakesh Goalan - Sangre Grande Hosiptal
Anil Kumar - Eric Williams Medical Sciences Complex
Email: bonesandjointssurgery@gmail.com
Marlon M. Mencia - Port of Spain General Hospital
Email: mmencia@yahoo.com

Presenting Author:
Atiba Aki Bua

Introduction:
Total knee arthroplasty rates are increasing exponentially in Trinidad. One of the most dreaded complications is deep infection. When revision procedures to reconstruct the joint fail or are not appropriate, one must turn to salvage operations. Knee arthrodesis represents the most functional salvage option available to the surgeon.

Case description:
A 62-year-old poorly compliant diabetic developed a deep infection following a total knee replacement. This was treated by removal of the implants and insertion of an antibiotic cement spacer. His multiple co morbidities made him a poor candidate for revision surgery, and it was agreed that he would undergo a knee fusion. After excluding active infection, the patient was taken to the operating theatre where the knee was fused using a docking technique which combined a femoral and tibial nail interconnected by a rush rod and further stabilized by two lateral plates. The patient recovered well from surgery and is now ambulating pain free with a mild limb and has had no recurrence of infection.

Discussion:
Knee fusion is arguably the best salvage option for a failed total knee arthroplasty. Conventional intramedullary rod fusion techniques typically involve expensive implants which need to be specially requested and imported into the country. The technique described illustrates a low-cost practical alternative that requires no special training and utilizes readily available implants.
Are we prepared to deal with the complications of primary knee arthroplasty?

DISSOCIATION OF A MODULAR HUMERAL PROSTHESIS: AN

UNCOMMON COMPLICATION

Authors:
Rondelle Skeete, Raakesh Goalan, Marlon M. Mencia, Curtis Young Pong, Dean Baiju

Author Affiliations:
Rondelle Skeete - Port of Spain General Hospital
Tel No:325-8908
Email: rnskeete@hotmail.com
Raakesh Goalan - Sangre Grande Hospital
Tel No: 791-7728
Email: raakg@yahoo.com
Marlon Mencia - Port of Spain General Hospital
Tel No: 756 3331
Email: mmencia@yahoo.com
Curtis Young Pong - Eric William Medical Sciences Complex
Tel No: 791-0235
Email: cypong_@yahoo.com
Dean Baiju - Eric William Medical Sciences Complex
Tel No:729-9725
Email: deanbaiju@hotmail.com

Abstract

Introduction:
Although dislocation is not uncommon, dissociation of the modular components in a modern 3rd generation humeral prosthesis is very rare. We present a case of just such an event following surgery for a posterior fracture dislocation.

Description:
A 47 year old male presented to the orthopaedic clinic with a 6 week old missed fracture dislocation of his left shoulder following an epileptic seizure. The humeral head defect was considered unreconstructable and the patient underwent a shoulder hemiarthroplasty. He defaulted from follow up and presented 2 months later with a painful stiff shoulder, radiographs at that time revealed dissociation of the modular head-neck junction. He subsequently underwent revision surgery and is recovering well.

Discussion:
We discuss this rare complication in light of the several technical surgical factors relating to the successful outcome of this procedure.
Should shoulder hemiarthroplasty for traumatic conditions be performed by the general orthopaedic surgeon?

THE 'FLIPPING PLATE' NOVEL USE OF A PROXIMAL HUMERAL LOCKING PLATE IN HINDFOOT ARTHRODESIS IN A PATIENT WITH CHARCOTS ARTHROPATHY.

Authors
Dr David Deane, DrAvinashToolsie, Dr Paula Kassie, Mr Emerson Budhoo
Mr Dean Baiju

Corresponding Author
Mr Emerson Budhoo
Eric Williams Medical Sciences Complex
ebudhoo2010@gmail.com
Tel 8687887134

Presenting Author: Dr David Deane

Speciality:Orthopaedics

Introduction:
The Diabetic Charcot's foot is a serious and potentially limb-threatening lower-extremity complication of diabetes.
It is characterized by varying degrees of bone and joint destruction secondary to underlying neuropathy and microtrauma. Management is aimed at obtaining a stable foot utilizing conservative or surgical treatment.

Case Description
A 55 year old female who is a known Type II DM was referred for a progressive, unstable lower limb deformity. Examination revealed that the hindfoot was fixed in varus. Radiographs demonstrated involvement of both the Tibiotalar and Choparts joint.
Hind foot arthrodesis was done with use of a proximal humeral locking plate due to limitations of implants. A Lateral approach was undertaken via a fibula osteotomy which was utilized as autologous bone graft for the procedure.

Discussion
The goal of treatment is to obtain a stable Stage III plantigrade foot, preferably with conservative measures such as Total Contact Casting. This is easier to achieve in the fragmentation phase as the joint is supple and mobile.
Unfortunately, this patient has a fixed deformity that required surgical osteotomy and arthrodesis. A multidisciplinary approach is necessary involving the vascular surgeons, endocrinologists, physiotherapists and Orthotics. This case also represents a novel use of a humeral plate for hindfoot arthrodesis by flipping it 180 degrees.

The role of orthopaedics in limb salvage of the Charcot's foot is slowly being accepted as an alternative to amputation in some centres in Trinidad and Tobago.

Images

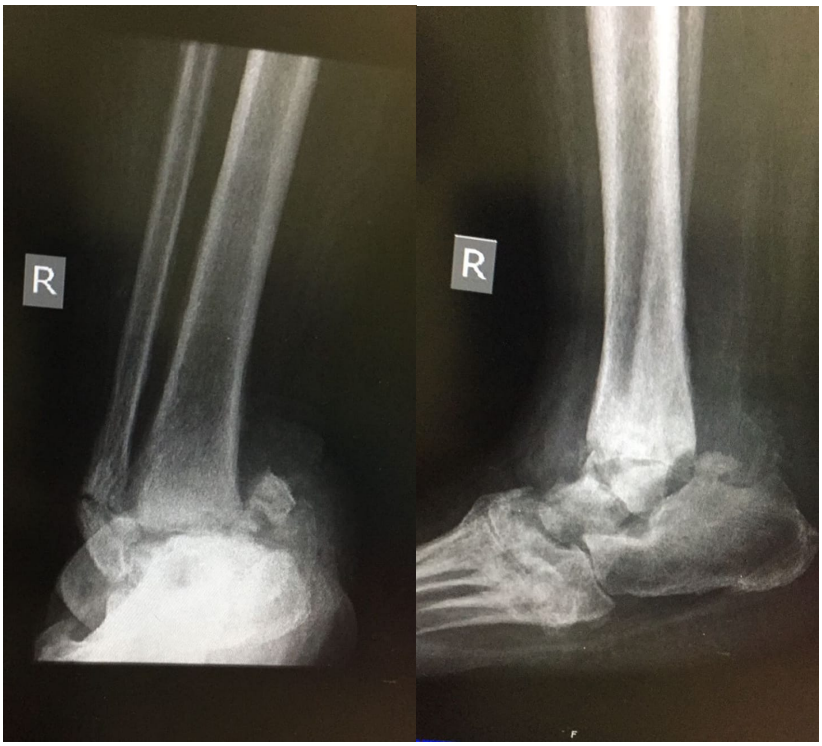


Figure 1 showing weight bearing xrays of foot with midfoot and hindfootcharcotsarthropathy in consolidated phase. Note also there is loss of Mearys angle on lateral view.

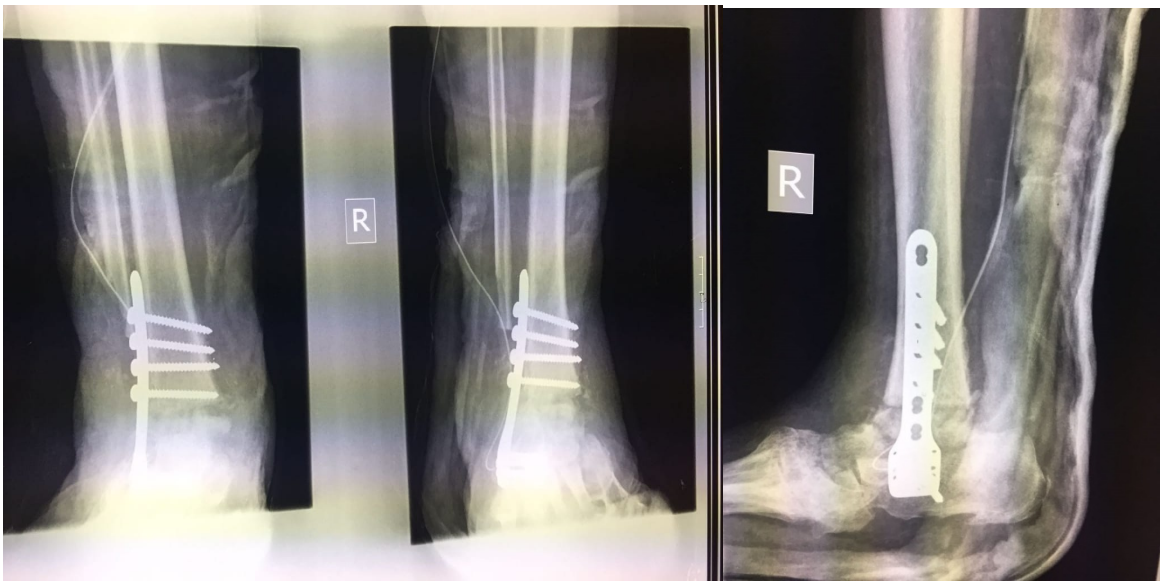


Figure two showing radiographs post arthrodesis with humeral locking plate insitu rotated one hundred and eighty degrees.

"DOCTOR, AM I ALLERGIC TO MY KNEE REPLACEMENT?"

Authors: Meghan Augustus, Marlon M. Mencia

Author Affiliations:
Meghan Augustus - Port of Spain General Hospital
Tel : 788-9400
Email: meganaugustus@live.com
Marlon M. Mencia - Port of Spain General Hospital
Tel: 756 3331
Email: mmencia@yahoo.com

Presenting Author:
Meghan Augustus

Abstract

Introduction:
Metal allergies are present in up to 10% of the population. Hypoallergenic implants have been developed to mitigate this complication. We describe a cutaneous allergic reaction in an Oxinium implant.

Case description:

A 56 year old female underwent bilateral staged total knee replacement (TKR) surgery utilizing Oxinium implants. She subsequently developed an eczematous skin reaction after each operation. Investigations excluded infection and skin patch testing for metals used in the TKR were negative. The condition resolved with the use of topical corticosteroids.

Discussion:
Eczematous skin reactions following TKR are not common and may not be due to metals used in the implant. Infection must be excluded. Topical corticosteroids should be considered in selected cases.
Is the use of hypoallergenic implants justified?

IS HAVING TWO BETTER THAN ONE? 1+1= NONE.

AUTHORS: Dr. C Dubay, Dr. D Persaud, Dr. R Khan
AFFILIATIONS: NCRHA
TELEPHONE CONTACT: 492 1193
EMAIL: dianapersaud612@gmail.com

PRESENTING AUTHOR: Cidi Dubay SPECIALTY: Paediatric Surgery
WORD COUNT: 197

ABSTRACT

INTRODUCTION:
Alimentary Tract Duplications (ATDs) are rare anomalies. They can occur anywhere throughout the gastrointestinal tract from the esophagus to rectum. Management of enteric duplications often requires operative intervention with preservation of the native blood supply and intestine. These procedures are usually very well tolerated with low morbidity. However, if not suspected ATDs can be life-threatening causing bleeding, abdominal pain, intussusception, volvulus and respiratory distress.

CASE PRESENTATION:
We present a case of a 2 day old female with a history of abdominal distension and persistent loops of bowel on abdominal x-rays. She had exploratory laparotomy that revealed tubular duplication. A few calculated decisions after measurements had to be made before proceeding. A length of 96cm of ileum (53% small bowel) resected out of a total 180cm small bowel, and preserving the ileo-caecal valve, thus avoiding short gut syndrome.

DISCUSSION:
What are the options available for management of tubular duplications?
For long tubular duplications, the blood supply can prove very difficult to preserve since the duplication is usually mesenteric. We reviewed the limited operative procedures that are possible and their drawbacks, together with the technical skills required. We also discussed the importance of recognizing ATDs as possible presentations.

NONOPERATIVE MANAGEMENT OF OMPHALOCOELE

Authors: Dr. Helen Bissoon, Dr. LakhanRoop, Dr. RambachanPersad

Presenting Author:

Dr. Helen Bissoon Department of Paediatric Surgery Level 9

San Fernando Teaching HospitalSouth West Regional Health Authority

LakhanRoop: Senior Medical Officer, Paediatric Surgery Department San Fernando Teaching Hospital

RambachanPersad: Head of department, Senior Medical Officer, Paediatric Surgery Department San Fernando Teaching Hospital

Key Words: Omphalocoele, Nonoperative delayed closure, Flamazine, Epithelialization

Introduction

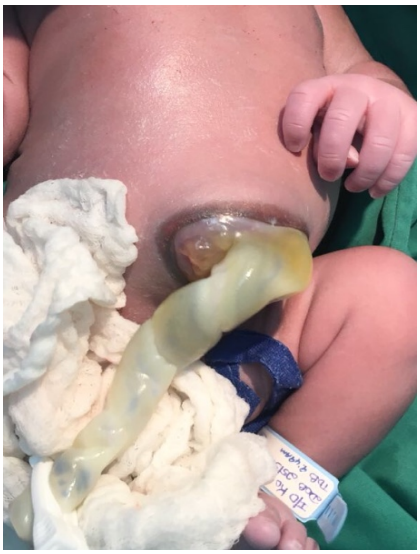
Omphalocoeles are characterized by eviscerated abdominal contents covered by a 3-part membrane through a congenital abdominal wall defect of the umbilical ring. Classification criteria, which are usually based on size of sac or defect and contents, vary across established literature, and determine management strategy: primary, staged or nonoperative delayed closure.

Case Description

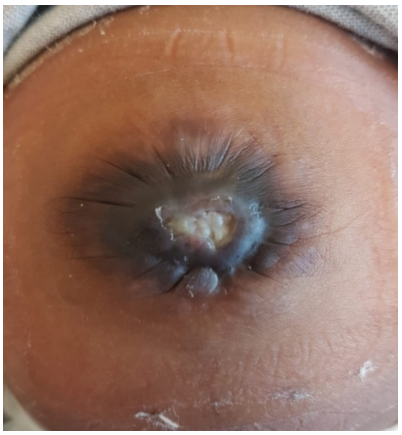
The patient was born at 37 weeks to a 22-year-old, healthy primigravida via emergency caesarean section for failure to progress. An omphalocoele was diagnosed on anomaly ultrasound and at delivery, the sac was 5cm in diameter with no intra-abdominal contents. Enteral feeds were commenced soon following delivery. Hospital stay spanned 21 days, with daily Silver Sulfadiazine dressings and phototherapy for neonatal jaundice. Outpatient clinic follow-up for twice weekly dressings followed discharge. No other congenital abnormalities were detected. Gradual echarification of the sac and complete neo-epithelialization occurred by 2 months. No complications of wound infection or signs of silver toxicity were noted. Surgical fascial closure of the patient's ventral hernia is pending.

Discussion

Topical approaches for managing omphalocoele were introduced in 1899. Silver Sulfadiazine offers broad antimicrobial coverage and a moist environment for rapid granulation tissue formation. Review articles in Journal of Pediatric Surgery indicate that primary nonoperative management with topical silver and delayed fascial defect closure, may lower operative mortality associated with early surgical closure, and decrease time to enteral feeding. Although optimal treatment remains controversial, there are trends toward this being the surgical standard for management of selected omphalocoeles.



Picture A: Omphalocoele at birth



Picture B: Omphalocoele after 6 weeks of topical Flamazine

RECURRENT INTUSSUSCEPTION IN A POST-OPERATIVE PATIENT WITH NEUROBLASTOMA

Authors: Reshma Doodnath, Barrie Landreth-Smith, Barbara Rampersad
Author Affiliation: Eric Williams Medical Sciences Complex
rdoodnath@gmail.com
Specialty: Department of Pediatric Surgery

Introduction:
Intussusception in children less than 2 years of age is usually idiopathic and ileo-colic. However, cases of recurrent intussusception should lead one to suspect an atypical intussusception.

Background:

A 2 year old male presented with stage IV neuroblastoma. After 5 cycles of chemotherapy, he underwent debulking of the intra-abdominal tumour. He had a relatively uneventful 3-day intensive care stay and was discharged after 8 days. He represented a month after with a 2 week history of intermittent abdominal pain and 3 day history vomiting following chemotherapy and was found to have an intussusception on routine CT. He underwent successful barium reduction of what appeared to be an ileocolic intussusception and a recurrence the following day. A second recurrence prompted a laparotomy. Intra-operative findings revealed a jejunal-jejunal intussusception with gangrenous bowel within the intussusception. A small bowel resection and primary anastomosis was performed.

Discussion:
Post-operative intussusception is most common within the first 3-5 days after surgery with a higher incidence post neuroblastoma resection. In this group of patients, the typical symptoms of intussusception are not always present and contrast studies are of limited value, since most cases are confined to the small bowel. In neuroblastoma it is postulated that circulating hormones such as catecholamines may affect peristalsis. Chemotherapy or radiotherapy are also important factors increasing the likelihood of post-operative intussusception by altering peristalsis. A high index of suspicion and prompt laparotomy will usually allow manual reduction of the lesion. An earlier suspicion of small bowel intussusception may have resulted in earlier laparotomy and manual reduction rather than resection.

CONSERVATIVE MANAGEMENT OF PAEDIATRIC HEPATIC ABSCESS.

AUTHORS: Dr. Paige Ali, Dr. Lakhan Roop, Dr. Rambachan Persad.
PRESENTING AUTHOR:
Dr. Paige Ali
Department of Paediatric Surgery Level 9 San Fernando Teaching Hospital
South West Regional Health Authority

KEY WORDS: Hepatic abscess, percutaneous drainage, consevative management
1. Dr. Paige Ali, House Officer, Department of Paediatric Surgery, San Fernando Teaching Hospital

2. Dr. Lakhan Roop, Specialist Medical Officer, Department of Paediatric Surgery, San Fernando Teaching Hospital
3. Dr. Rambachan Persad, Head of Department, Specialist Medical Officer, Department of Paediatric Surgery, San Fernando Teaching Hospital

INTRODUCTION
Hepatic abscess is rare in the Paediatric population. It is more prevalent in developing countries, and is very uncommon in Trinidad. Although it mostly occurs in immunocompromised patients, it may also manifest in the healthy child. Clinical and radiological investigations are required for diagnosis and follow-up. Management can be surgical or conservative depending on the patient's clinical state, assisted by haematological and radiological investigations.

CASE REPORT
Multiple hepatic abscesses were found in a previously well 8 year old female. She presented with a 2 week history of fever, epigastric pain, vomiting, dizziness and a presyncopal episode. The patient lived in a home with all amenities. On examination, the patient was febrile and tachycardic with hepatomegaly and she eventually became icteric as her LFTs became deranged. Ultrasound and CT showed 2 areas of ill-defined hypodensities on the liver. She was placed on IV antibiotics and percutaneous drainage was considered. On EUA, on table ultrasound demonstrated shrinkage of the lesions, indicating response to conservative management and percutaneous drainage was deferred. A causative organism was never identified on cultures. The patient was discharged on day 17 post-admission with ultrasound and CT evidence of significant abscess shrinkage. Outpatient ultrasounds showed complete resolution.

DISCUSSION
An uncommon case of multiple, cryptogenic hepatic abscesses was diagnosed in a Paediatric patient. Conservative management with antibiotics proved successful and surgical drainage of these abscesses was not required. Literature search revealed several cases of successful conservative management of hepatic abscesses.

CONSERVATIVE MANAGEMENT OF A GRADE 5 RENAL LACERATION IN A THREE YEAR OLD PATIENT

Sabrina Labban, Lakhan Roop, Rambachan Persad,
Correspondence:
Dr. S Labban
House Officer
Department of Paediatric Surgery
South West Regional Health Authority
Trinidad

Key words: Renal injury, Nephrectomy, Blunt trauma, Angiogenesis, Embolization
1.Sabrina Labban: House officer, Paediatric SurgeryDepartment, San Fernando General Hospital
2. Lakhan Roop: Consultant Paediatric Surgeon, Paediatric Surgery Department, San Fernando General Hospital
3. Rambachan Persad: Consultant Paediatric Surgeon and Head of Department
Paediatric Surgery Department, San Fernando General Hospital
Specialty: Paediatric Surgery

Introduction:
Renal trauma accounts for 10% of all blunt abdominal injuries in children. In the early 2000s there was a shift from surgical management to a more conservative approach. This paper highlights the successful conservative management of a 3 year old patient with a grade 5 renal laceration.

Case Description:
A three year old presented to SFGH with multiple trauma secondary to being rolled over by a small bus that was moving at a a low velocity. Patient was assessed and resuscitated. He was intubated and bilateral thoracostomy tubes were inserted. Frank haematuria was noted after catheterization. He had a CT with IV contrast that revealed a Grade 5 renal, grade 3 splenic laceration and bilateral haemorthoaces. He was resuscitated with IV fluids and had blood products. The patient was admitted to ICU and remained stable on conservative management. He was eventually fit for discharge from ICU and recovered uneventfully.

Discussion:
In the early 2000s conservative management became the standard of care for renal trauma due to the high rate of nephrectomy secondary to early surgical intervention in renal trauma. According to the AUA, conservative management avoids unnecessary nephrectomy and preserves renal function. This patient was managed conservatively despite him having an AAST grade 5 renal laceration because he responded to initial resuscitative efforts and remained stable with conservative efforts. This followed emerging data.

AN UNUSUAL CASE OF PYOMETRA IN INFANCY

AUTHORS: Dr. D Persaud, Dr. R Khan
AFFILIATIONS: NCRHA TELEPHONE CONTACT:
EMAIL: dianapersaud612@gmail.com PRESENTING AUTHOR: Diana Persaud
SPECIALTY: Paediatric Surgery, Urology, Gynaecology
WORD COUNT: 250
ABSTRACT

INTRODUCTION:

Pyometra, the accumulation of pus within the uterine cavity, is very rare in childhood. One cause is persistent urogenital sinus (PUGS) which is a cloacal anomaly, and presents as a single common passage for urethra and vagina in females. Diagnosis can be a difficult task as patients present with recurrent urinary tract infections, abdominal mass and obstructive uropathy. Treatment includes a temporary drainage procedure and deferring definitive surgical correction, usually vaginoplasty, as infection resolves.

CASE DESCRIPTION:

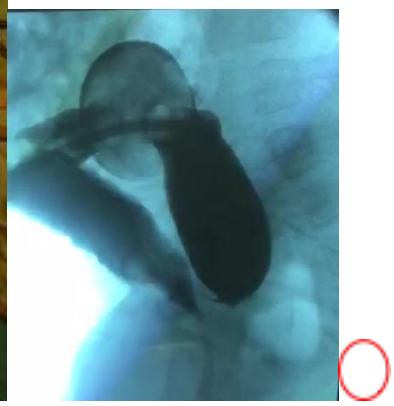
We present a 2 month old female with features of Patau's syndrome and a discoloured umbilical hernia. She was admitted for a urinary tract infection, but developed abdominal compartment syndrome of unknown cause. An urgent CT scan showed a large mass arising from the pelvis suggestive of a urachal cyst. An emergency exploratory laparotomy was done. An enlarged uterus containing 400 ml of pus was found with one common opening in the perineum. A uterine drain was left in situ. A MCUG and contrast study through uterine drain revealed a high confluence PUGS.

DISCUSSION:

Why was the diagnosis delayed?

What is the next step?

Due to the rarity and lack of obvious signs and symptoms, diagnosing this condition has been difficult worldwide. The odds were stacked against early diagnosis due to poor antenatal care and hence, lack of serial antenatal ultrasounds, as well as, late MCUG review done after hydronephrosis was detected. Management was delayed but ultimately satisfactory with a view for definitive treatment after cystoscopy is done to confirm the abnormality suspected.



VATS Thymectomy, the Initial Experience

Authors: Ramnarine I, Browne K, Persaud S, Ramsingh K
Department: Thoracic Surgery
Eric Williams Medical Sciences Complex, Champ Fleurs, Trinidad & Tobago
Institution : Eric Williams Medical Sciences Complex, Champ Fleurs,
Country: Trinidad and Tobago

Presenter: Kevin Browne
Corresponding Author's information: Dr. Kevin Browne,
House Officer, Cardiothoracic Surgery
Tel.: 1868 7715516
Email: Kev1n@hotmail.com

Introduction:
Video-assisted Thorascopic Surgery (VATS) has been available since 2008 in Trinidad for pleural and pulmonary-based procedures. However, progress to advanced procedures has been slow partly due to a lack of suitable cases. Thymectomy is the gold standard for all patients who have myasthenia gravis and a thymic mass. We present the first documented case in the Caribbean of a thymectomy for Myasthenia Gravis being performed by a VATS.

Case Description:
A 24-year-old female presented with generalized weakness, dyspnoea and blurry vision. She was diagnosed as having Myasthaenia Gravis and treated with Pyridostigmine, Prednisolone and Azathioprine. A mediastinal mass suggestive of a thymoma was seen on CT. She underwent VATS Thymectomy without complication.

Discussion:
Minimal access thoracic surgery is routine. However complex VATS procedures are not common for a variety of reasons. These are presented for discussion. Case selection is important and controversy still exists whether the optimal approach to thymectomy for Myasthaenia is via VATS or an open procedure.

THE OCCULT BREAST PRIMARY AND THE DIFFICULTY IT PRESENTS.

Persaud SDN, Sagubadi S, Bascombe N, Ramnarine I
Eric Williams Medical Sciences Complex, Champ Fleurs, Trinidad and Tobago
Shirvanie@hotmail.com
Specialty: General Surgery, Thoracic Surgery, Oncology
Word count:214

Introduction

We present a patient with metastatic breast cancer with an occult primary. We discuss the challenges in diagnosis and management.

Case Description

A 57-year-old female with no co-morbidities presented with cough, dyspnoea and chest pain for one month. She had a right pleural effusion that was aspirated and was negative for malignancy. CT Chest showed a large right pleural effusion, pleural thickening and a pleural nodule. Video-Assisted Thoracoscopic Surgery (VATS) pleural biopsy revealed a poorly different Adenocarcinoma. A breast cancer primary was diagnosed by immunohistochemistry (IHC). Estrogen receptor and GCDFP-15 receptor were positive from the pleura. Mammography was negative. MRI Breasts showed a 1cm BIRADS 2 right-sided lesion, also retrospectively noted on the initial CT Chest. She was discussed at the multidisciplinary meeting and started on chemo-radiotherapy.

Discussion

Patients with pleural effusions must be investigated, even in the presence of systemic illness that could be responsible. Pleural thickening and nodules on CT prompted the VATS biopsy. IHC is essential in establishing the diagnosis in metastatic disease. Small breast lesions or those with benign features can make detection difficult, especially in larger breasts. The questions remain whether hormone therapy, radiation or any surgery to the breast is still necessary.

CHYLOTHORAX AND THE SURGEON

Authors:
Medical Student
Faculty of Medical Sciences
U.W.I. St. Augustine
Contact: 1-868-475-9773
Email: theanaguerra@hotmail.com

Ian Ramnarine

FRCS Ed, FRCS (C Th)
Cardiothoracic Surgeon
Eric Williams Medical Sciences Complex
North Central Regional Health Authority
Contact: 1-868-662-4027
E-mail: ianramnarine@ncrha.co.tt

SreekanthSagubadi

Consultant Thoracic Surgeon
Eric Williams Medical Sciences Complex
North Central Regional Health Authority
Email: sreesagubadi@gmail.com

Presenting Author: Theana Guerra

Specialty: Thoracic Surgery and Malignancy

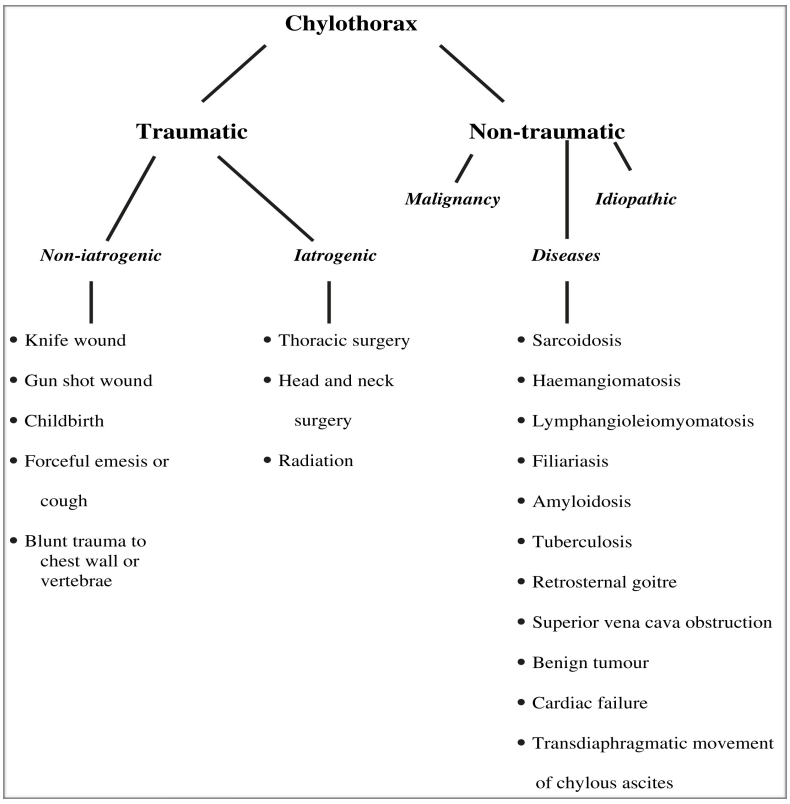
Word Count: 175

Introduction
Chyle in the chest presents a diagnostic dilemma. We present a case of chylothorax and lung cancer and suggest a pathway for investigation, diagnosis and management options.

Case Description
A 72-year-old male ex-smoker with a fifty pack year history presented with cough, haemoptysis, dyspnoea and weight loss. Chest X-Ray revealed a 10-15% right pleural effusion. Thoracentesis yielded 500mls of white, milky fluid and diagnosed as a chylothorax. A large right hilar mass extending into the anterior and middle mediastinum was identified on CT. Biopsy confirmed small cell lung carcinoma.
Once the clinical diagnosis of chylothorax was made, a multi-pronged management strategy was executed including intercostal drainage, chemical pleurodesis with bleomycin, nutritional treatment with a medium-chain triglyceride diet and radiation to treat the underlying primary lung malignancy.

There was a subsequent decrease in drainage of chyle.

Discussion



The diagnosis of Chylothorax poses difficulties that we present and discuss.
Successful management requires a multi-disciplinary approach that is seldom addressed. These are also presented.

Figure 1: Aetiology of Chylothorax*

*Image from:
Chylothorax: Aetiology, diagnosis and therapeutic options
McGrath E.E., Blades Z., Anderson P.B.
(2010) Respiratory Medicine, 104 (1) , pp. 1-8.